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ABSTRACT

This document consists of papers that received recognition in a competition sponsored by the Center for Substance Abuse Treatment and the National Rural Institute on Alcohol and Drug Abuse. The competition sought to focus attention on problems in providing treatment and prevention services for drug and alcohol problems in rural areas. The papers address a wide array of issues and populations, from schoolchildren to alcohol-dependent adults to criminal offenders. The introductory paper entitled, "Bringing Excellence to Rural and Frontier America: Advocacy for Substance Abuse Services in the 1990s" (Susan L. Becker) suggests what local and state programs can do to help overcome the barriers that interfere with gaining support from policymakers. The first- and second-place award papers are respectively entitled "Adult and Adolescent Community Correctional Services Program" (William S. Tanner) and "The Upper Peninsula Teen Leadership Program: Marquette-Alger Intermediate School District" (Dee Lindenberger). Third-place award papers include: (1) "You Can't Get There from Here: The Choice/Skyward Experience" (Rachel Cyr Henderson, Susan F. Long); (2) "School Teacher's Role in a School-Community Alcohol Intervention Program" (Ian M. Newman and others); (3) "Challenges in Rurally Based Alcohol and Drug Abuse Treatment Services" (James A. Armstrong); (4) "Issues in Providing Alcohol and Drug Abuse Services in Rural/Frontier Counties of California" (Kenneth R. Fleming); (5) "Building Community-Based Abuse Prevention Coalitions" (Jim Meek); (6) "Cultural Diversity As a Positive Force in the Treatment of Native American Alcohol and Other Drug Abuse" (Anne Muldoon); (7) "Transitional Recovery" (Larry R. Seybold); and (8) "Project TEA: Iowa State Penitentiary Substance Abuse Program" (Robert E. Schneider and others). (LP)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Rural Issues in Alcohol and Other Drug Abuse Treatment

Technical Assistance Publication Series

10

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Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Foreword

The Center for Substance Abuse Treatment (CSAT) and the National Rural Institute on Alcohol and Drug Abuse (NRIADA) are pleased to sponsor this publication jointly. For too long, the problems of alcohol and drug abuse in rural areas have received short shrift in the national consciousness. As national studies show, those who live in rural areas are just as likely to have alcohol and other drug problems as those who live in large and small cities. The choice of addictive substances may differ, but the prevalence of abuse is virtually the same for country and city dweller alike. Yet rural areas face special difficulties in providing high-quality treatment and prevention services to their widely dispersed populations— often without the help of public transportation.

To help focus attention on the special service delivery problems of rural areas, CSAT and NRIADA sponsored an "Award for Excellence" competition in the Fall of 1992. Individuals and agencies from rural areas across the country were invited to submit papers describing their efforts in providing services to those with alcohol and other drug problems. The goal of the competition was to elicit—and then publicize—the innovative and unusual strategies, approaches, and research findings from rural programs.

In response to this challenge, CSAT and NRIADA received an excellent collection of papers addressing a wide array of issues and populations, from school-children to alcohol-dependent adults to criminal offenders. The submitted papers are printed here: some describe local programs, while other programs affect entire regions. Readers will find many unusual and innovative strategies. To name just one example—an isolated treatment agency on the coast of Maine solved their patients' transportation problem by offering space for a "club" to the local recovering community; the flourishing club now provides a safe gathering place, recreational events and holiday meals, and a place of comradeship and support to patients.

We are pleased to offer the field this fine group of papers, with their many ideas for meeting the challenge of providing high-quality services to rural areas. Knowing what to do is the critical first step. But those developing programs must also be prepared to act as advocates with local and State policymakers, who can help provide the understanding, funding, and other resources to make new initiatives possible. The first paper in this collection, originally presented at the NRIADA's annual conference, suggests what local and State programs can do to help overcome the barriers that interfere with gaining support from policymakers. Working together—with collaboration between the public and private sectors—we can make a real and meaningful difference for rural people suffering from alcohol and other drug problems, and bring excellence to rural America.

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Bringing Excellence to Rural and Frontier America: Advocacy for Substance Abuse Services in the 1990s

Susan L. Becker*

Since President Nixon declared the first modern war on drug abuse in 1974, America has been concerned with substance abuse. While there is acknowledgement that alcohol and other drug use are problems for all of society, media and political attention seem locked on scenarios suggesting that substance abuse is predominantly, if not uniquely, a problem of the inner cities. Participants in this eighth annual conference of the National Rural Institute on Alcohol and Drug Abuse are acutely aware that this is not so. For too long, the national consciousness and the national agenda of the "War on Drugs" have been oblivious to the alcohol and drug problems of rural and frontier America.

Prevalence of Substance Abuse Problems in Rural America

The question is not whether alcohol and other drug use is a problem in rural and frontier areas. Prevalence data provide ample evidence that the problem exists. In 1990, a report on rural drug abuse by the General Accounting Office stated that total substance abuse rates are about as high in rural and frontier States as in nonrural States. What differentiates between rural and nonrural areas is that the prevalence rates for particular drugs may vary. For example, the rate of cocaine use appears to be lower in rural areas than in cities, whereas prevalence rates for other drugs, such as inhalants, may be higher.

Alcohol is the most widely abused substance in rural areas. However, more than 4 of every 10 rural high school seniors have tried marijuana; 1 in 11 rural high school seniors reports having tried cocaine. Among students in rural areas, the lifetime, annual, and 30-day prevalence rates for stimulants, inhalants, sedatives, and tranquilizers are comparable to those of seniors in nonrural areas (Johnston et al. 1989, pp. 42-46). Most prison inmates in rural States have abused alcohol, other drugs, or both (U.S. General Accounting Office 1990).

Clearly, the problem exists and has been documented. This presents rural and frontier States with a dilemma. When a problem and its constituency are invisible to the majority of the public, how can a rural State develop the necessary support not only to acknowledge the problem and the need, but also to develop excellence in the State's prevention and treatment services?

Louis Swanson, in assessing rural development problems, identified six current barriers to action. I believe these barriers apply to the problem of how we can achieve excellence in the delivery of substance abuse services in rural and frontier America. These barriers include:

1. Flawed views of rural America
2. Serious limitations to the social and health data on rural areas
3. Failure to see rural areas as connected to the larger U.S. society
4. A perception that many rural problems do not have a viable political solution
5. Absence of a unified rural constituency, combined with the presence of formidable opposition to rural programs other than farm price supports
6. State and Federal fiscal crises (Swanson 1990, pp. 21-29).

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*This paper is adapted from a speech presented by Susan L. Becker, Associate Director for State Programs, Center for Substance Abuse Treatment, at the eighth annual conference of the National Rural Institute on Alcohol and Drug Abuse. The speech was the keynote address for the Harold E. Hughes Awards Luncheon on June 10, 1992.

Barrier #1: Flawed Views of Rural America

I believe the most formidable barrier to excellence lies in the flawed views of rural America that are commonly held. This barrier concerns the economics of health care delivery in rural and frontier areas. It is commonly believed that wages, labor costs, and building space are less costly in rural areas and that, as a result, rural health care services are less expensive to deliver compared to their costs in urban areas (Public Law 102-321, Section 1933 and Section 707).

This view is flawed, however, in that it fails to consider the "diseconomies of scale" and the available infrastructure that differentiate urban and rural settings (U.S. General Accounting Office 1990). Thus, while building costs may be lower in rural settings, rural and frontier areas face a unique challenge—that of providing physical access to services for clients who may live significant distances from the treatment or prevention site. Rural States also face the challenge of recruiting and retaining qualified professional staff who live in proximity to the site, but who must be willing to travel almost continuously.

Similarly, the coordination of services may prove more costly and more labor intensive within the rural delivery system because of the difficulties posed by distance, service availability, and accessibility. When calculating per client expenditures, it is imperative to include such critical expense items as travel, availability of specialized personnel, accessibility of other needed health and mental health services, and infrastructure costs. Inclusion of these expenses can drastically affect the accuracy of cost projections on providing substance abuse services to the population in need.

Barrier #2: Serious Limitations to Social and Health Data

The second barrier—the limits imposed by the scarce social and health data concerning rural and frontier areas—exacerbates the first barrier of flawed views. This information gap could be remedied through utilization of existing indicator data or through the planning and health resources of the States and State universities. Unfortunately, most rural and frontier jurisdictions and providers have been slow to utilize these available resources.

Available National Data

The National Household Survey is one example of data available for rural and frontier States to use in documenting their need for services. The 1988 survey, conducted by the National Institute on Drug Abuse, compared the relationship of drug use to demography by analyzing age-controlled data for large metropolitan areas, small metropolitan areas, and nonmetropolitan areas (National Institute on Drug Abuse 1989).

Significantly, the Household Survey showed that large metropolitan areas and rural areas had similar rates for drug use among youth aged 12 to 17 years—approximately 9 percent. Such figures suggest that youth in this age group have a comparable need for prevention and education efforts, whether they live in rural or in large metropolitan areas.

Young adults aged 26 through 34 in both large metropolitan and nonmetropolitan areas also had comparable rates of drug use—15 percent and 13 percent respectively. The rates of drug use among this age group are significant, since they imply that these young adults have a substantial level of chronic drug use and a need for appropriate treatment resources. These findings have significant implications concerning the type of substance abuse services that are needed in rural areas. More importantly, they demonstrate the extent to which drug use in rural areas is similar to use in both large and small metropolitan areas.

Local Data Sources

At a time when State and Federal resources are limited, individuals as well as service providers need to gain maximum benefit from all existing sources of data. While the most ideal data would be a quantified needs assessment for the population served, familiarity with existing local agency statistics can generate a great deal of supporting and helpful information. Local health departments can provide data about the rates of infectious diseases associated with alcohol and other drugs of abuse in their particular areas, as well as data concerning local teenage pregnancy rates. Local justice agencies can provide data concerning the rates of crime and of accidents associated with alcohol and other drug use.

Learning to use and regularly review such data would not only go a long way toward overcoming the flawed views of others, it would also convert some flawed self-views of rural America. Those who live in rural and frontier States are no longer secure from the threat of HIV, tuberculosis, or drug-related crime. Further, the needs of rural people who are being served may be changing. The service system must be

sensitive, flexible, and adaptive to meet these evolving needs.

While it may once have been true that rural and frontier areas had a problem only with alcohol, this is certainly not true today. As stated earlier, existing studies demonstrate that alcohol is the most widely and commonly used substance, but that rates of drug use for rural youth and young adults are comparable to prevalence rates in large and small metropolitan areas.

The availability of heroin is limited in rural areas; however, this does not negate the possibility that rural people can be addicted to narcotics acquired through illicit trade in prescription drugs. Intravenous drug use is most commonly associated with heroin and narcotics, but abusers of methamphetamine also commonly administer their drugs intravenously. The prevalence of intravenous drug use, regardless of the agent used, has significant implications. For instance, analysis of Arkansas prison data revealed that, in the State's four rural counties with a high rate of intravenous methamphetamine use, the rate of HIV infection was also elevated.

More accurate and specific data is needed before it will be possible to understand fully the extent of substance abuse problems in rural areas. Nevertheless, there is ample evidence to suggest that the problem is extensive and that aggressive intervention is needed.

Barrier #3: View of Rural Problems as Disconnected From U.S. Society

The third barrier to excellence is the failure to view rural and frontier areas and their problems of alcohol and other drug abuse as connected to the larger U.S. society. The day for insularity has passed. We cannot afford to see substance abuse problems as a separate and distinct issue.

The abuse of alcohol and other drugs must be seen as a public health problem and addressed accordingly. When we view the abuse of alcohol and other drugs in a public health context, we can speak forcefully about the consequences of the use and abuse of these agents in a manner that connects the consequences to the local community and to the State at large. When the connection between rural substance abuse problems and the larger community is successfully made, it will create new stakeholders invested in the successful resolution of rural problems. While some control may be lost, the benefit will be a more effective network of problem solving that will develop through increased resources and the investment of more people in a positive outcome.

Direct and Indirect Costs of Alcohol and Drug Abuse

How do alcohol and other drug use relate to public health services and expenditures by society at large? Drug and alcohol use directly affect the extent of expenditures needed to provide services and also affect the type and extent of health care and support services needed by a community. The process of educating policymakers must emphasize that the direct and indirect costs of alcohol and drug abuse are shared by all of society.

Beyond the costs of treatment and prevention services, there are a wide range of health problems associated with drug and alcohol use; these associated health problems are significant factors in calculating the overall cost of substance abuse to society. Consider the following estimates for the cost of health and remedial care for health problems related to drug and alcohol use:

- A cost of $785 is estimated for a single case of hepatitis B (CDC 1990; CDC 1992a; Alter et al. 1990)
- A cost of $50,125 is projected for the treatment of one person with the human immunodeficiency virus (HIV) (CDC 1991a; CDC 1992b; Kahn 1992)
- An expenditure of approximately $102,125 is estimated for each case of acquired immunodeficiency syndrome (AIDS) (CDC 1991b; Kahn 1992)
- Current estimates approach $1,400,000 to cover lifetime medical and institutional care for one child with the fetal alcohol syndrome (FAS) (Weeks 1990)

Each of these and many more health problems are significantly associated with the misuse of alcohol and other drugs. The indirect and direct costs of alcohol and other drug use should be presented as justification for both prevention and treatment services. The most significant point about these costs to society is that, through prevention and early intervention services, these costs may be significantly reduced. Every case of alcohol and drug abuse that effective outreach, prevention, and treatment can identify early or prevent entirely will produce cost savings for State and Federal Medicaid expenditures and for society as a whole.

Those of us in the substance abuse field must learn to demonstrate not only that treatment works, but also that it is a wise investment in today's economy. Without intervention, our communities will endure the continued costs associated with drugs and alcohol—costs of accidents and injuries as well as additional expenditures for

disability, lost productivity, and costs secondary to criminal activity.

Impact of Rural Supply, Production, and Distribution of Drugs

In addition to the health care and crime costs generated by rural drug abuse, policymakers must be made to consider the crucial role that rural and frontier areas play in the overall supply, production, and distribution of drugs. Drug cultivation and drug laboratories are certainly more likely to be found in less populated rural and frontier areas.

Drug smuggling—whether overland or by air in light aircraft—is a phenomenon of extremely rural and frontier areas; this smuggling is supported by our extensive interstate transportation networks. As a result of both availability and organized and active distributors, the drug use problem at production/importation points in rural and frontier areas may be worse than in most large metropolitan areas.

Barrier #4: Perceived Lack of A Viable Political Solution

There is a perception that many rural problems do not have a viable political solution. This flawed view acts as a barrier to effective program development and therefore must be challenged head-on with quantitative data from national and local studies.

Every rural and frontier advocate needs to educate community decisionmakers in local businesses and local government on scientific findings, demonstrating that rehabilitation, education, and prevention efforts in substance abuse are effective and work. Such efforts can increase the community's economic opportunities, because potential employers want safe, healthy, and reliable work forces and communities. Every program needs to participate in some formal quantitative evaluation studies. Innovative programs should be fully documented as effective treatment modalities and as cost-effective intervention models.

Overcoming each of these barriers requires that rural and frontier communities be clear in their goals. They need to be effectively organized and to be active in directing all available resources toward their achievement.

Barrier #5: Absence of a Unified Rural Constituency

Unfortunately, a fifth barrier has been the absence of a unified rural constituency able to advance concerns and needs and to propose solutions. Each rural and frontier State would benefit from having an active and organized group of substance abuse providers, a government-sponsored advisory council, and a rural caucus. When political leaders and funding agencies are making decisions, they look to organized groups who can speak with a unified voice for a given population; they look for data that can provide valid and reliable proof of a position. This requires local and State organizational efforts, as well as efforts among those across State lines who have similar interests and causes to advance.

Once organized, efforts must be made at all levels of decisionmaking through active communication and involvement with many individuals and groups. Those who should be approached, involved, and worked with include:

- Local and county governments
- State agencies
- State legislative committees
- Coalitions with other community groups

It is important to hold meetings with State governors, to inform Federal legislators of needs and concerns, and to present the group's agenda to relevant Federal agencies. The National Rural Institute on Alcohol and Drug Abuse itself can serve as a powerful vehicle for organizing and directing the interests of rural and frontier communities. With all of the competing interests for funding and special consideration, those with an organized and active constituency are most likely to receive attention and action.

Barrier #6: State And Federal Fiscal Crises

Finally, consideration must be given to the sixth barrier—current State and Federal fiscal crises. Advocates for rural program excellence need to be aware of and to understand the elements of a particular State budget crisis. It is critical for advocates to educate themselves about how substance abuse problems relate to budgetary problems. Ask yourself these questions. How much do you know about your State budget crisis? Does your State have a problem of income, a problem of outlay, or a combination of the two? Which outlays pose the greatest strain on the budget?

The substantial outlays for prison costs, Medicare, and Medicaid can all be related to the costs associated with chronic alcohol and other drug abuse. In this circumstance, modest investments in substance abuse treatment and prevention can produce large cost offsets and can contribute significantly to the

management of these "runaway" outlay problems in State budgets. To a lesser extent, costs such as unemployment compensation and food stamps are also budgetary outlays that can be related to substance abuse.

Advocates for rural programs must have an organized constituency. In addition, the organization must be armed with valid and reliable data that will serve to educate decisionmakers about the needs of rural and frontier areas and the means for resolving problems in a cost-effective manner.

Having presented this overview of flawed views of rural America and the barriers associated with these views, where do we all go from here? As a first step, you need to evaluate yourself and your organization about how prepared you are to overcome these barriers effectively. The scale below has been prepared as a checklist to help you assess both strengths and areas of untapped potential. Using the assessment scale, score yourself and assess where you might strengthen your efforts and expand your activities.

As we all know, there is much to be done. I hope this overview will assist each of you in determining—for your State—where you go from here.

Assessment Scale	
1	No effort or knowledge in this area
2	Minimal effort or knowledge in this area
3	Significant effort or knowledge in this area
4	Activity completed or knowledge complete in this area

Rural Drug Abuse Systems Assessment

Points Possible	Activity	Points Scored
4	Calculation of cost (dollar outlay) per client you serve	
4	Cost comparison of programs comparable to yours in urban/suburban areas	
4	Completion of a formal, quantified needs assessment	
4	Knowledge of rates of infectious diseases associated with alcohol and other drug use	
4	Knowledge of rates of crime associated with alcohol and other drug use	
4	Knowledge of rates of accidents associated with alcohol and other drug use	
4	Knowledge of teenage pregnancy rate	
4	Demonstration to an employer, insurer, or legislator the cost-offsets for substance abuse treatment	
4	Participation in a formal, quantitative evaluation	
4	Familiarity with relevant portions of State budget	
4	Meeting with gubernatorial/legislative staff on relevant budgetary problems	
44	**Total Possible** **Total Score**	

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Adult and Adolescent Community Correctional Services Program

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This paper describes the development of the Community Correctional Services Program which seeks to reduce recidivism by establishing user accountability, directly impacting upon the efficacy and efficiency of the seven county jails, the seven county probation and parole offices, the district and superior courts, and the local police departments.

The multi-jurisdictional effort brought together Federal, State, county, and local resources to meet the needs of the offender population. By combining the Federal Bureau of Justice Assistance (represented by the State JAA) and the Federal Health and Human Services Office of Treatment Improvement (now the Center for Substance Abuse Treatment) (represented by the State Office of Substance Abuse), the seven-county consortium is now able to provide services to both the adult offender and the at-risk adolescent population.

It is the philosophy of the consortium and the Community Correctional Services Program to network with community-based services whenever possible in order to best serve rural Maine.

Purpose

The overall goal of the Community Correctional Services Program is to reduce the recidivism of the substance-abusing offender by creating an atmosphere of user accountability, providing alternative sentencing, and testing for drug use among offenders. The immediate goals of the program are:

- To identify and meet the treatment needs of adult and juvenile drug-dependent and alcohol-dependent offenders.
- To provide treatment alternatives at the pre-adjudication and pre-trial phases of the criminal justice system for perpetrators posing no danger to the community.
- To provide drug testing for the identification, assessment, referral, case management, and monitoring of drug-dependent offenders. The program collects region-specific data on the type and pattern of substance abuse in order to contribute to long-range law enforcement, corrections, and treatment planning.

Method

It is becoming increasingly apparent that, as State funding and other resources decrease, there must be a concerted effort to maximize Federal, State, county, and local community efforts to provide a coalition approach to services.

Kennebec Valley Regional Health Agency is a rural, community-base,d nonprofit health care provider with a major division of substance abuse and mental health services. Its Community Correctional Services Program recognizes that to ensure services to at-risk youth and adults in the correctional system, it is necessary to form multiple strategic alliances with organizations providing such services to identified populations and their families.

In 1986, Kennebec Valley Regional Health Agency began providing substance abuse services to the Kennebec County Jail. The services were provided in-house with no identified formal, community-based support.

As a result of this lack, the intended impact on recidivism was minimal. It soon became apparent that services needed to extend beyond the jail to the community. These community-based services were necessary to ensure a smooth transition from the institution and continuity of treatment. Our experience indicated that without them, approximately 47 percent of those treated in jail would reoffend by committing new alcohol- or drug-related crimes. If we had continued in our original direction, services in the institution would have had little impact.

Funding for initial substance abuse services was provided by Kennebec and Franklin Counties and the State of Maine. These community-based services included case management by a substance abuse counselor and an alternative to incarceration, the First and Second Offender

Operating Under the Influence (OUI) Program.

Sheriffs from five other counties joined the sheriffs from Kennebec and Franklin Counties as well as probation and parole officers to support the development of a consortium.

In Maine, probation officers were significantly hampered by large caseloads (adult: 200 plus per officer; adolescent: 60 plus); responsibility for expansive geographic areas; layoff days that reduced their client time by 2 days per month; and the inability of 85 percent of their clients in need of substance abuse services to pay for these services.

At the time of the development of the multiple strategic alliance, a recidivism study was conducted. The results of the study indicated that 64 percent of the people on probation reoffended.

Kennebec County Sheriff Frank Hackett had just been elected president of the Maine Sheriff's Association when he and the sheriffs of Lincoln, Knox, Penobscot, Sagadahoc, Somerset, and Franklin Counties joined us to develop the consortium. We presented to the sheriffs the idea of a consortium and explained the logic behind its development. The seven counties represented 52 percent of the voting population of the State. The sheriffs were the only officials in the counties elected by a plurality of the vote. We were able to show that the impact on recidivism and the information resulting from a unified treatment, law enforcement, and correctional effort could be profound.

Having obtained the sheriffs' commitment, we identified that, to be successful in our recidivism reduction efforts, it was also necessary to involve the district attorneys of the seven counties. We met with each DA and learned that if the plan could reduce dockets, speed the court process, and garner judges' support, then the DAs would lend their support as well.

Based on our previous work with them, we were able to enlist support of the Superior Court Judges of Kennebec and Franklin Counties. As a result, we also received the support of the other superior and district court judges.

The collaboration between Kennebec and Franklin Counties and Kennebec Valley Regional Health Agency resulted in development of the Community Correctional Services Program, which also provides services to Lincoln, Knox, Sagadahoc, and Penobscot Counties.

The consortium of sheriffs then applied for a Federal Bureau of Justice Assistance Grant. Sheriff Hackett was named contract administrator, and Community Correctional Services was designated as the sole service provider. The award was made in 1988, with funds going to the Maine Justice Assistance Council through the grant from the Bureau of Justice Assistance.

The State Department of Corrections, specifically Probation and Parole, offered its cooperation based on its agreement with our philosophy of accountability, responsibility, and consequences.

Our clinicians feel strongly that accountability, responsibility, and consequences are the basis of behavioral changes, and that though we cannot excuse it, we can provide explications for the behavior. The correctional population must be held to these standards if there is to be any success in the recovery process. Probation's perception of the "do gooder social worker" had to be put to rest in order to gain their support. This was accomplished by close communication and cooperation with the probation officers built on a positive history of work together.

Content Area

From our work with Probation and Parole, the need to provide substance abuse services and mental health assessment to adolescents at risk became apparent. We identified the fact that rural youth experienced distinct difficulties in accessing affordable services. In order to truly have an impact on this population, we had to accomplish rural outreach.

In 1990, the consortium of sheriffs and the Community Correctional Services Program—with the additional support of Probation and Parole, local law enforcement, area schools, courts, and district attorneys—developed and presented a comprehensive grant to service at-risk youth aged 14-22. The grant was funded by the Office of Treatment Improvement (now the Center for Substance Abuse Treatment). Services have now been in place for 2 years.

To ensure that the Community Correctional Services Program bridged gaps between corrections, law enforcement, and clinical services and maintained credibility with our collaborators, it was necessary to develop a somewhat unique clinical program approach.

The Community Correctional Services Program identified seven program areas that needed to be adapted in order to ensure the continuity of services to the correctional population:

1. Services needed to be available to clients at the time of entry to the correctional system. These services were designed to allow for pre-adjudication and pre-sentencing evaluation and screening with recommendations for potential diversion being provided to probation and parole officers as part of the pre-sentencing investigation. To ensure counselors' consistent

contact with both the client and probation and parole officers, counselors' offices are located either at Probation and Parole or within a short walking distance.

Our experience over a 7-year period indicates that 72 percent of the cases presented to Probation and Parole and the court have been accepted in part or in full into the sentencing process. The Community Correctional Services Program currently provides services from seven Probation and Parole offices and eleven other locations in the seven counties' rural communities.

2. Loss of client contact with Probation and Parole during the time of incarceration was identified as a major problem. This loss of contact is not unique to rural communities, but is a serious problem in terms of recidivism in rural States.

   The program reports the client's involvement in counseling while incarcerated and also reports specific release dates to Probation and Parole. The release date information facilitates early probation contact and continuity of services to the community.

3. Psychosocial educational groups were developed in the seven counties. The structure of the group allows for early access to services. Each jail client is referred directly to the group upon release from jail. The psychosocial modality allows for a larger numbers of clients, including the dually-diagnosed, to be served in each group. As a result, it is possible for each group to serve up to 25 clients. The program currently has 17 active groups in the 7 counties. Each group has a time limit of 16 weeks.

   Clients needing more extensive services are referred either to outside clinical services or to our own advanced treatment groups. Those clients who successfully complete the Community Correctional Services Program by completing their treatment plan are recommended for probation termination. Approximately half of all clients referred to the program receive early termination from Probation and Parole.

4. Once the screening and assessment process is completed, clients are referred to psychosocial education groups and to our case management process. Case management permits the counselor and Probation and Parole to maintain contact with the client and at the same time refers the client to appropriate clinical and support services that aid in rehabilitation.

   Traditionally, rural States have had difficulty accessing services. This case management system allows the program to search out and refer to the variety of services necessary for the clients' successful integration to the community. Clients who leave the program either through early termination or through completion of the psychosocial educational and/or the treatment group, and who are not in need of further clinical support, are provided with case management services that extend to the end of their probation.

   To ensure user accountability, the clients in case management receive sporadic urine monitoring. If the clients' results are positive, they return to the formal program with a new treatment plan.

5. The Community Correctional Services Program has assumed the responsibility of drug testing for the clients of Probation and Parole. Testing acts as a strong additional deterrent to client use and allows for user accountability.

6. The adult and adolescent programs pay particular attention to gaining access to the whole family whenever possible. The consortium has identified the fact that long-lasting intervention requires contact with the family.

7. Probably the single most important part of the program is the willingness of the counselors to regularly communicate the status of the clients to Probation and Parole. We do not report the content of counseling sessions, but we do report attendance and dangerous behavior.

The adolescent program draws its treatment modality from the adult program. However, it focuses primarily on working with at-risk youth before they become involved with the criminal justice system. There are modifications that include a wilderness diversion component. The wilderness program allows the adolescents to spend 1 day every 6 weekends in the wilderness. During this day, they explore ways to develop self-esteem and participate in team-building exercises.

Rural and frontier States, especially in New England, are faced with the real problem of adolescent alcohol abuse. According to our adolescent client contact, 88 percent report that their primary drugs are not a problem, but that alcohol is clearly the gateway drug. Furthermore, because alcohol is so readily available, it is difficult to intervene on its negative impact.

Findings

Correctional services in rural and frontier States are faced with many

difficulties, including the responsibility of covering expansive geographic areas, large numbers of probationers with varied criminal backgrounds, and the sense on the part of many probation officers that they are only bandaging. It has been repeatedly expressed that the officers find themselves setting priorities according to their probationers' level of criminal involvement, because they do not have enough time for their caseloads.

The Community Correctional Services Program has offered Probation and Parole the opportunity to lessen its caseloads. Probation and parole officers are able to rely on the Correctional Services Program Counselors' ability to work with their chemically abusing and addicted adults and adolescents.

Conclusion

The Community Correctional Services Program and Probation and Parole have seen a 37 percent reduction in recidivism among the adult population served. Currently, the program serves 368 diverted, at-risk adolescents and 94 of their families.

The State's Operating Under the Influence Program currently has a 38 percent recidivism rate. For the 7 years that we have run the alternative OUI program, our recidivism rate has held at 6 percent.

I am convinced that the program works for both adults and adolescents. It keeps adults out of jail, saving the State and the counties $65 per day room and board. It helps to keep adolescents in school.

Recommendations

My only recommendation is that you be willing to look at the model to see how it applies to your rural or frontier State or county. The program or parts of it could easily be replicated.[1]

[1]Other materials on our program include *First and Multiple Offender Alternative Sentencing Policies and Procedures Manual, Adolescent Thumbs-Up Diversion Program Policies and Procedures Manual*, intake and screening instruments (adult and adolescents), "Urine-Monitoring Policies and Procedures," and "Wilderness Experience Development Plan."

The Upper Peninsula Teen Leadership Program: Marquette-Alger Intermediate School District

Dee Lindenberger
Upper Peninsula Teen Leadership Program
Marquette-Alger Intermediate School District
Marquette, Michigan

The process of networking to provide quality substance abuse prevention/early intervention services to high school students from across the Upper Peninsula (UP) of Michigan was formally undertaken in 1985. To maximize the limited financial and human resources available, a group of professionals from the major substance abuse service providers across the Peninsula decided to work collaboratively on a project called the Upper Peninsula Teen Leadership Program (UPTLP).

The UPTLP is a comprehensive prevention and early intervention program for high school students. It is a peer leader program that prevents substance abuse by strengthening resiliency factors. It promotes the concept that prevention is not something we can do *to* our teens, but something we must do *with* them, as partners. It consists of a variety of innovative student trainings held at different host school sites throughout the year. To meet students' needs for supportive adults and environments upon returning home from the regional trainings, school and agency personnel and community members also participate in workshops that are offered throughout the year to enhance the students' skills in working supportively with student leaders in their schools and communities.

Over the program's 9-year history, a strong network has emerged that includes professionals, community members, and students from all over the UP—a team enriched by the active participation of both Native American and non-Native American persons. The development of a team identity that occurs among the adult and student UPTLP partners is quite similar to the process described by Peter Senge in his book, *The Fifth Discipline*, regarding the development of aligned "learning teams." It involves (1) the ability to think in terms of "systems theory," (2) the development of a positive vision, (3) ongoing personal learning and growth, (4) the development of a sense of community and team, and (5) the willingness to explore new personal and/or agency paradigms, or "mental models."

These concepts and skills are purposefully incorporated into the UPTLP to provide a conceptual and programmatic framework in which a diverse group of professionals, community members, and high school students can see themselves as part of a larger system. Students and adults have ongoing opportunities for skill development and support that would otherwise not be available within isolated communities. The UP network has continued to work together over the years to meet new challenges and program needs. As a result of this continued collaboration, UP schools wishing to implement Student Assistance Programs have had ready access to necessary training, technical support, and some additional funding sources.

Because of its successful history of promoting collaboration, the Marquette-Alger Intermediate School District has gained recognition throughout the State of Michigan and currently provides leadership in the development of a statewide student assistance network. Funded by several State agencies, this network has two tasks:

- To develop a guidebook with recommendations for conducting Student Assistance Program trainings. The purpose of the trainings is to help prepare diverse groups of educators and community people to work together as aligned teams in their schools and communities.
- To promote greater levels of alignment among State agencies

involved with student assistance programs in the State.

Program resources have become increasingly scarce over the past few years. There is no question that the current quality and availability of services could not have been possible without the collaborative teamwork of this network of students, caring adults, and professionals. The UP network is not without gaps; however, it continues to grow in momentum, as well as in numbers.

Purpose and Background

> *. . . a major, underlying cause of the development of social problems can be traced to the gradual destruction of naturally occurring social networks in the community. The social, economic, and technological changes since the late 1940's have created a fragmentation of community life, resulting in breaks in the networks and linkages between individuals, families, schools, and other social systems within a community . . . necessary for healthy human development . . .* (*Research Update*, Fall/Winter 1991-92, National Organization of Student Assistance Programs and Partners).

This paper addresses the need for "strategies for coalition building and networking within rural and/or frontier areas."

The UPTLP represents a collaborative effort by schools, agencies, and community members from across the entire UP of Michigan to provide a programmatic framework of training, resources, and support that can help to reestablish or enhance positive networks and linkages between individuals, families, schools, and other social systems. Its purpose is *prevention*: prevention of the onset or escalation of substance abuse and other self-destructive behaviors among UP teens and prevention of relapse for youth returning from substance abuse treatment services.

Although risk factors are identified and addressed at trainings, the major emphasis and strategies are directed toward developing internal and external protective factors that will help develop resiliency among our youth. This includes providing programming and networks designed to enhance a teen's internal assets (such as communication and coping skills and personal convictions) as well as to strengthen a variety of external assets (positive relationships in families, peer groups, schools, and community) (Troubled Journey: A Profile of American Youth, 1992).

The UP is an expansive area bordered by the southern shoreline of Lake Superior and the northern shoreline of Lake Michigan. It is connected to the Lower Peninsula only by the 5-mile-long Mackinac Bridge. The UP is rural, with a population density of 19 people per square mile. Its 16,500 square miles of land consist of wilderness and farmland, interspersed with isolated pockets of population. Although the UP represents just under 30 percent of Michigan's land mass, less than 4 percent of the State's population live there. The economy is dominated by mining, extractive industries, logging, and tourist trade. Layoffs and cutbacks have become a way of life to many residents, and a large segment of the population lives near or below poverty level.

UP communities, like rural communities in other parts of the country, have struggled to find ways to provide quality and cost-effective prevention and early intervention services to their youth. High-risk factors inherent in rural living include limited numbers of trained school and community professionals, scarce financial resources, and large distances between communities, which limit opportunities for supportive networking.

However, agencies and schools are committed to using these limitations as a motivation to share information and pool human and financial resources to make effective substance abuse prevention and intervention programs available to youth all over the area—in short, to network.

This process was formally started in 1985. The result is a dynamic and effective UPTLP, a coalition effort making state-of-the-art prevention and early intervention programming available to youth and adults. Over its 8-year history, it has created a strong aligned team that includes professionals, community members, and students working together to promote leadership, resiliency, and positive lifestyle choices.

Methodology

There are two aspects of the UPTLP's methodology to consider:

- The UPTLP as a prevention and early intervention program for high school students
- The UPTLP as a structural framework for networking and collaboration between school and agency professionals, parents, and community members and groups

The methodology and the underlying philosophy that make the UPTLP effective as a youth prevention/intervention and aftercare support program also make it an effective vehicle for networking and coalition building among adults. Five major aspects of the program's methodology play a role in the powerful impact of the program in both arenas. They closely mirror the disciplines

identified by Peter Senge in *The Fifth Discipline* as necessary components for the development of aligned learning teams:

1. *Systems awareness and process thinking* is incorporated into all levels of programming to provide a sense of the "big picture." In addition to providing a framework for understanding the dynamics and roles of high-risk behaviors in individuals, families, schools, and communities, it also provides a larger structure of available resources and support for positive change. The emphasis on process thinking helps to promote a sense of timing and pacing. Meaningful changes (within both personal and organizational systems) may take time and require ongoing interventions and support.

2. *A positive vision* propels and guides the shaping of program efforts with students, as well as the working relationships in the adult network. The goal is to find ways to move toward our objectives. The vision includes the wish to help young people achieve their full potential as human beings and as learners. Students and adults alike are motivated and guided by this positive vision to reach their fullest potential and to enjoy the process along the way.

3. *Personal learning and growth* is encouraged among students as well as adults who participate in the programs. Presentations on topics such as "Understanding Family Systems," "Developing Healthy Relationships," "Enabling," "Feelings and Defenses" are followed by opportunities for discussion and sharing in a small-group format, permitting individuals to integrate information on levels that are meaningful and personally motivating in their lives.

4. *A sense of community and team* is developed that includes diverse groups of individuals coming from a large geographic area. This feeling can only develop in a safe environment of mutual trust and respect. Honest and respectful communication provides the foundation for a safe learning and working environment.

Enhancing the communication skills (such as listening, problem-solving, assertiveness, and caring confrontation) of students and adults is an important goal of the trainings. These skills foster positive relationships among youth and adults and promote a sense of belonging in a supportive community and team. These are important aspects of prevention on every level and are vital in building an effective coalition or network.

5. *Mental models* of "the way things are" or "the way I've always done it" are examined, and perhaps challenged, in the hope of generating new ways of doing or being. A fresh perspective opens doors to powerful new insights and behaviors: it can change the way a popular football player views and relates to a handicapped classmate or draw two turf-squabbling agencies together to accomplish what neither could accomplish alone. The goal is to remain open to discovering and learning new ways of seeing and responding.

The methodologies and contents of the UPTLP's prevention and early intervention program and its structural framework for networking and collaboration will be discussed separately.

Prevention Program:[1] Methodology and Content

It is important for youth to have an understanding of the skills and dynamics that determine whether a system (such as family, peer group, or school) will be "growth encouraging" or "growth discouraging." (These terms are preferred as they sound less accusatory than terms such as "functional" and "dysfunctional.")

Systems and Process Thinking

Virginia Satir identified four aspects that she believed all family systems share. These aspects can be observed within individuals and other systems as well (schools, peer groups, communities, agency networks, etc.):

1. Self-worth—Core feelings and ideas about oneself. (Are individual's feelings of self-worth positive or negative?)

2. Communication patterns—Verbal and nonverbal methods people use to relate meaning to one another. (Are communication patterns open, honest, and respectful, or indirect, manipulative, and filled with mixed messages?)

3. System rules—Overt and covert expectations for behavior. (Are the rules meant to protect and support individuals or to control and punish them?)

4. Links to society—Ways people relate to other people and institutions outside the family. (Is it an open system or a closed system?)

Understanding that there is a continuum of possible norms within different systems in each of

[1] When describing UPTLP, the term "prevention program" includes all levels of prevention, i.e., prevention of onset (primary prevention), of escalation (early intervention), and of relapse (aftercare support of youth returning from treatment services).

these areas, it helps to lay a working foundation on which youth can build an understanding of how and why some systems are supportive and nurturing (growth encouraging) while others are stressful and emotionally painful (growth discouraging). They practice and learn skills that help them develop mutually supportive and respectful relationships with peers, family members, and other adults.

The UPTLP functions throughout the UP and includes youth and adults from diverse backgrounds and communities. Periodic regional trainings provide formal opportunities for youth to get together for ongoing skill building and support.

Perhaps of equal importance, however, is the development of regional peer groups. Students forge deep bonds at the trainings; they tend to maintain the relationships as sources of motivation and support that bridge the time between trainings. This support is especially significant for students in rural areas who have limited choices of friends and peer groups.

A student returning home from chemical dependency treatment to a school that has only five to ten other students in the same grade faces difficult challenges when most, and possibly all, of these classmates use drugs. A peer group of close friends who understand and support a chemical-free lifestyle can make the difference in a youth's ability to remain sober, even if the group is spread across a large area.

A Positive Vision

Positive visions of the future, important goals and values, and life's many wonderful possibilities motivate youth to make healthy lifestyle choices far more effectively than do negative, avoidance-based visions of what they should **not** do (e.g., "Just Say No!"). As Peter Senge points out, these positive visions must be encouraged and supported.

There are two fundamental sources of energy that can motivate. . . fear and aspiration. The power of fear underlies negative visions. The power of aspiration drives positive visions. Fear can produce extraordinary changes in short periods, but aspiration endures as a continuing source of learning and growth.

Instead of conceptualizing prevention as something we do to our youth to prevent certain behaviors, we can think of it as something we do with them. As guides and partners, we can promote and support their development as resilient human beings and positive peer leaders.

In a study of more than 40,000 youth, grades 6 through 12, the Search Institute identified 20 protective factors. Of these, 14 were internal assets: communication skills, friendship-making skills, self-esteem, positive view of personal future, etc. A total of 16 were external assets: communication with parent(s) or another adult, positive school climate, positive peer influence, etc.

The institute's study "Troubled Journey" revealed that the more protective factors a child possessed, the lower the number of risk factors and high-risk behaviors. Other studies indicate similar correlations between strengthened protective factors and reduced levels of substance abuse.

In other words, prevention of drug and alcohol problems happens automatically if we focus our efforts on building resiliency and positive leadership skills in our youth. The primary prevention strategy used in the UPTLP develops teens' resiliency and positive leadership potential by strengthening internal and external protective factors.

Personal Learning and Growth

The most significant learning takes place when an individual finds personal meaning or relevance in new information and skills and applies them practically to improve the quality of his or her life. When that happens, it is likely that a self-sustaining cycle will develop as achievements feed the motivation to continue learning and refining new skills.

Positive reinforcement keeps people involved as they grow and gain from their experience. The program's structural design encourages personal learning and growth. Large group presentations are interspersed with small "skill groups" in which students meet with two trained, adult facilitators. These skill groups provide time to process and integrate the information from the presentations. They also offer opportunities to practice both intrapersonal and interpersonal communication skills in a safe environment.

A Sense of Community and Team

Diversity is an important element in the effectiveness of the program. For many years, educational research has consistently demonstrated that the most dramatic learning, for all participants involved, happens in heterogeneous groups. If an environment is supportive, safe, and challenging, participants will most likely benefit from its diversity.

Many kinds of students from many different peer groups come to the UPTLP. Some are outgoing and some shy; some are athletes and some think that walking to the television constitutes exercise; and some have never touched a drop of alcohol or other drugs while some are working on their recovery. Increasing numbers of special need students (for example, physically

handicapped or learning disabled) have participated in trainings over the years.

The program has also included a large number of Native American students. Recognizing the special needs of the Native American students in the program has made increasing understanding of and respect for Native American culture, and multi-culturalism in general, important objectives of the program.

The adults in the program also come from a variety of cultural and ethnic backgrounds. They include school and agency professionals, parents, and community members. The teens learn from their wisdom and experience. They discover that adults can be fun, caring, and helpful. In exchange, the adults learn from the teens' insights and energy; they discover that teens can be fun, caring, and capable of dynamic leadership. Imaginary lines that typically separate the adults from the youth and the "jocks" from the "geeks" and the "brains" seem to disappear as the participants learn more about each other as individuals.

A sense of being valued as part of a diverse, yet cohesive, community and team develops over a weekend- or week-long UPTLP training. This development involves the following:

- Getting to know other teens and adults as human beings and understanding that everyone has "gifts and missing pieces"—that everyone has something to contribute, but no one is perfect.
- Being confronted with the need to take responsibility for one's own behavior in a way that is respectful and caring.
- Taking risks to learn new skills, share feelings and ideas, and play together.
- Learning about one's strengths and identity.
- Developing a positive vision of a meaningful, personal future.
- Learning to trust oneself as well as others.

Mental Models

Youth are given opportunities to explore a variety of situations by applying new mental models. For example, by viewing how families function from a systems perspective, a youth can better comprehend interrelationships and dynamics of the "big picture." This leads to a fuller understanding of how certain behaviors might exacerbate problem situations at home or in school and, in the long run, be counterproductive.

To maintain resilience throughout life, youth also need positive mental models for envisioning their personal futures and for dealing effectively with stress and conflict. The trainings and support network of the UPTLP allow youth to learn and practice these new models of perception and behavior.

UP Teen Leadership Trainings

More than 1,000 high school students and 500 adults participate in regional trainings at different sites over the course of the year. Each school or community has a contact person who provides followup and support to students after the trainings. Contact persons are also encouraged to work with students as advocates and advisors in the execution of action plans developed at the summer training and at other activities throughout the school year.

UP Teen Leadership Summer Training, the core training of the UPTLP, is a week-long program held on the campus of Northern Michigan University. A student assistance program training for school and agency professionals and community members is offered concurrently. It provides opportunities for adults and students to talk, work, and play together. Major presentation topics for students include "Understanding Family Systems," "Adolescence and Chemical Problems and Enabling," "Loss and Grief," "Intensity or Intimacy (Healthy Relationships)," "Yourselves," "Natural Highs," and "What It Means To Be a Leader."

Social competency and communication skills are taught through role play and rehearsal. Students practice these skills in realistic situations during skill groups. Students are taught reflective listening, assertiveness, decisionmaking, problem-solving, dealing with anger, and caring confrontation. A healthy environment is structured to model and encourage the development of responsibility, trust, respect for self and others, sensitivity to and celebration of individual differences, and ways to have chemical-free fun (see figures 1 and 2).

Teen Leadership PIP-Fest Weekends are booster programs offered several times each school year. PIP-Fests (Partners in Prevention Festivals) provide ongoing support and skill building. Approximately 200 students and staff live in a high school for the weekend. They participate in presentations, skill groups, and recreational activities from Friday evening to Sunday afternoon. These weekends are very similar to the summer training in content and focus.

Athletic Chemical Awareness Programs are offered one to three times each year. They address some of the special needs, concerns, and opportunities that athletes have as leaders and powerful role models in their schools. Again, the underlying philosophy and training strategies remain consistent with the summer training. Role plays are used to

Figure 1
Leadership Training Agenda

Student Schedule
Upper Peninsula Teen Leadership Training

June 14-20, 1992
Hunt Hall–Northern Michigan University

Sunday, June 14

Hunt Hall Lobby	1:00-2:30 p.m.	Registration/Room Assignment
Quad II Cafeteria	2:30-3:30 p.m.	**Opening Show/Orientation***
Quad II Cafeteria	3:30-4:30 p.m.	Energizer
Quad II Cafeteria	4:00-4:45 p.m.	**Mixed Group Discussion***
University Center	4:45-5:45 p.m.	Dinner
Quad II Cafeteria	6:00-6:45 p.m.	**What's a Peer Helper?**
Quad II Cafeteria	6:45-7:15 p.m.	Energizer
Quad II Cafeteria	7:15-8:15 p.m.	Defenses and Feelings*
Skill Group Rooms	8:30-11:00 p.m.	Skill Group

Monday, June 15

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	9:00-10:30 a.m.	**Understanding Families***
Skill Group Rooms	10:30-12:00 noon	Skill Group
University Center	12:00-1:00 p.m.	Lunch
Quad II Cafeteria	1:45-4:00 p.m.	**Communication: Focused Listening/Caring Confrontation**
Quad II Cafeteria	4:00-4:45 p.m.	Aerobics
University Center	4:45-5:45 p.m.	Dinner
Quad II	6:00-6:45 p.m.	Photo Session (Please be *prompt!*)
Quad II Cafeteria	7:00-8:30 p.m.	**Adolescence and Chemical Problems/Enabling***
Skill Group Rooms	8:30-11:00 p.m.	Skill Group
	11:30 p.m.	In Rooms
	12:00 midnight	Lights Out!

* Indicates Large Group Presentations, which are held with members of the Student Assistance Program Core Team Training. **Bold type indicates Large Group Presentations.**

Figure 1 (continued)
Leadership Training Agenda

Tuesday, June 16

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	8:30-8:45 a.m.	Stretch/Wake-Up Energizer
Quad II Cafeteria	8:45-9:15 a.m.	**Sexual Abuse***
Quad II Cafeteria	9:15-9:45 a.m.	**Depression***
Quad II Cafeteria	10:00-10:45 a.m.	Stretch Break
Quad II Cafeteria	10:45-11:15 a.m.	**Managing Weight Without Eating Disorders***
Quad II	10:45-11:15 a.m.	Juice Break
Quad II Cafeteria	11:15-12:15 p.m.	**Loss and Grief***
University Center	12:15-1:30 p.m.	Lunch
Quad II Cafeteria	1:45-3:00 p.m.	Fishbowl Group*
Skill Group Rooms	3:00-4:45 p.m.	Skill Group
Quad II Cafeteria	4:45-5:30 p.m.	Aerobics
University Center	5:45-7:00 p.m.	Dinner
Quad II Cafeteria	7:00-8:00 p.m.	Intensity or Intimacy? **(Healthy Relationships)***
Skill Group Rooms	8:15-11:00 p.m.	Skill Group
	11:30 p.m.	In Rooms
	12:00 Midnight	Lights Out!

Wednesday, June 17

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	8:30-8:45 a.m.	Stretch/Wake-Up Energizer
Quad II Cafeteria	8:45-9:15 a.m.	**Growing Through Conflict/Coping With Stress**
Quad II	9:50-10:15 a.m.	Juice Break/Energizer
Hunt Hall Galley	10:15-11:45 a.m.	**Multi-Culturalism and School Climate***
University Center	12:00-1:00 p.m.	Lunch

(Please note: There will be two activities during the next time block. Half the skill groups will meet promptly at 1:00 in front of the University Center to go on field trip. The other half of skill groups will prepare for student presentations in Quad II. Groups will switch activities on Thursday. Skill groups to be attending each activity will be announced).

University Center	1:00-2:15 p.m.	Field Trip
Quad II	1:15-2:30 p.m.	Student Presentation Preps
Quad II Cafeteria	2:45-3:30 p.m.	Public Speaking
Wildcat Den/Lawn	3:45-6:00 p.m.	Picnic *(New Games begin at 3:45 on lawn in front of Wildcat Den. Picnic will be served at 5:00 p.m.)*
Wildcat Den/Lawn	6:00-6:45 p.m.	**Native American Culture***
Quad II Cafeteria	7:15-8:15 p.m.	**12 Step Programs**
Skill Group Rooms	8:30-11:00 p.m.	Skill Group
	11:30 p.m.	In Rooms
	12:00 Midnight	Lights Out!

Figure 1 (continued)
Leadership Training Agenda

Thursday, June 18

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	8:30-9:00 a.m.	Stretch/Wake-Up Energizer
Quad II Cafeteria	9:00-10:30 a.m.	**Taking Care of Yourself**
Quad II	10:30-11:00 a.m.	Juice Break/Energizer
Quad II Cafeteria	11:00-11:45 a.m.	**Living As If It Matters**
University Center	11:45-1:00 p.m.	Lunch

(Please note: There will be two activities during the next time block. Half the skill groups will meet promptly at 1:00 in front of the University Center to go on field trip. The other half of skill groups will prepare for student presentations in Quad II.)

University Center	1:00-2:15 p.m.	**Field Trip**
Quad II	1:15-2:30 p.m.	**Student Presentation Preps**
Quad II Cafeteria	2:45-3:30 p.m.	**Natural Highs**
Quad II Cafeteria	3:45-4:40 p.m.	Aerobics
University Center	5:00-6:00 p.m.	Dinner
Quad II Cafeteria	6:15-7:45 p.m.	Student Presentations
Skill Group Rooms	8:00-11:00 p.m.	Skill Group (*last work session*)
	11:30 p.m.	In Rooms
	12:00 Midnight	Lights Out!

Friday, June 19

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	8:30-9:00 a.m.	Stretch/Wake-Up Energizer
Quad II Cafeteria	9:00-9:45 a.m.	**On Being A Leader**
Quad II	9:45-10:00 a.m.	Juice Break/Energizer
Quad II Cafeteria	10:00-11:45 a.m.	**Student Program Sharing/Action Planning**
University Center	11:45-12:45 p.m.	Lunch
Quad II Cafeteria	1:00-2:00 p.m.	**Core Team/Student Closure***
Quad II Cafeteria	2:15-3:45 p.m.	Natural Highs Sharing
Skill Group Rooms	4:00-5:30 p.m.	Skill Group (*Prepare for skits.*)

(Please note: Times indicated for the Awards Ceremony and the Talent/No-Talent Show are approximate and will depend on the number of people participating.)

West Hall Dining Room	6:00-7:00 p.m.	Banquet
West Hall Dining Room	7:00-7:45 p.m.	Awards Ceremony
Quad II Cafeteria	8:15-10:00 p.m.	Talent/No-Talent Show
Quad II Galley	10:00-Midnight	(Dance!)
Quad II Cafeteria	Midnight-12:30 a.m.	Stories/Music To Slow Down To
	12:30 a.m.	In Rooms
	1:00 a.m.	Lights Out!

Saturday, June 20

University Center	7:00-8:30 a.m.	Breakfast
Quad II Cafeteria	8:30-10:00 a.m.	Clean Up/Pack Up
	10:00-11:00 a.m.	Re-Entry/Closing Ceremony
	11:00 a.m.	Farewell!

Figure 2
Core Team Training Agenda

Core Team Schedule
Comprehensive Student Assistance

June 14-19, 1992
Hunt Hall—Northern Michigan University

Sunday, June 14

Hunt Hall Galley	12:30-1:00 p.m.	Registration
Hunt Hall Galley	1:00-2:15 p.m.	Orientation
Quad II Cafeteria	2:30-3:30 p.m.	Teen Orientation*
Quad II Cafeteria	3:30-4:00 p.m.	Energizer
Quad II Cafeteria	4:00-4:45 p.m.	**Mixed Group Discussion***
University Center	4:45-5:45 p.m.	Dinner
Hunt Hall Galley	6:00-7:00 p.m.	**SAP Overview***
Quad II Cafeteria	7:15-8:15 p.m.	**Defenses and Feelings***
Small Group Rooms	8:30-9:30 p.m.	Process Groups

Monday, June 15

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	9:00-10:30 a.m.	Understanding Families*
Small Group Rooms	10:30-12:00 noon	Process Group
University Center	12:00-1:00 p.m.	Lunch
Quad II Cafeteria	1:15-3:15 p.m.	**Family Roles Come to School**
Quad II Cafeteria	3:30-4:30 p.m.	Process Groups
University Center	4:30-5:45 p.m.	Photo Session (*Please be prompt*)
Quad II Cafeteria	7:00-8:30 p.m.	Adolescence and Chemical Problems/Enabling*

Tuesday, June 16

University Center	7:00-8:15 a.m.	Breakfast
Quad II Cafeteria	8:30-8:45 a.m.	Stretch/Wake-Up Energizer
Quad II Cafeteria	8:45-9:15 a.m.	**Sexual Abuse***
Quad II Cafeteria	9:15-9:45 a.m.	**Depression***
Quad II Cafeteria	9:45-10:00 a.m.	Stretch Break
Quad II Cafeteria	10:00-10:45 a.m.	Managing Weight Without Eating Disorders*
Quad II	10:45-11:15 a.m.	Juice Break
Quad II Cafeteria	11:15-12:15 p.m.	**Loss and Grief***
University Center	12:15- 1:30 p.m.	Lunch
Quad II Cafeteria	1:45-3:00 p.m.	Fishbowl Group*
Small Group Rooms	3:00-5:00 p.m.	Process Groups

(Option: Process groups may choose to end early if group members would like to participate in Aerobics from 4:45-5:30 in Quad II Cafeteria.)

University Center	5:00-6:45 p.m.	Dinner
Quad II Cafeteria	7:00-8:00 p.m.	**Intensity or Intimacy (Healthy Relationships)***

Figure 2 (continued)
Core Team Training Agenda

	Wednesday, June 17	
University Center	7:00-8:30 a.m.	Breakfast
Hunt Hall Galley	8:45-9:45 a.m.	Prevention: What Is It?
Quad II	9:45-10:15 a.m.	Juice Break/Energizer
Hunt Hall Galley	10:15-11:45 a.m.	Multi-Culturalism and School Climate*
University Center	11:45-12:45 p.m.	Lunch
Hunt Hall Galley	1:00-3:30 p.m.	**Prevention: Some of the Pieces:** **1. Cooperative Learning (1:00-2:00)** **2. Paper Programming (2:15-3:00)** **3. Prevention Curricula (3:00-3:30)** (Elementary/Secondary Split Track)
Small Group Rooms	3:45-4:45 p.m.	Process Groups
Wildcat Den/Lawn	4:45-5:45 p.m.	Dinner
Wildcat Den/Lawn	6:00-6:45 p.m.	Native American Culture*
	Thursday, June 18	
University Center	7:00-8:45 a.m.	Breakfast
Hunt Hall Galley	9:00-10:30 a.m.	Intervention Process
Quad II	10:30-10:45 a.m.	Juice Break
Hunt Hall Galley	10:45-11:30 a.m.	Treatment/Followup Support
University Center	11:30-12:30 p.m.	Lunch
Hunt Hall Galley	12:45-1:30 p.m.	School-Based Small Groups
Hunt Hall Galley	1:30-1:45 p.m.	Stretch Break
Hunt Hall Galley	1:45-3:15 p.m.	**Core Teams/Crisis Response Teams in Action**
Small Group Rooms	3:30-5:00 p.m.	Process Groups
University Center	5:00-6:00 p.m.	Dinner
Hunt Hall Galley	6:15-7:15 p.m.	**Building a Strong Core Team**
	Friday, June 19	
University Center	7:00-8:45 a.m.	Breakfast
Hunt Hall Galley	9:00-10:00 a.m.	Partnership Prevention: Home/Community
Quad II	10:00-10:30 a.m.	Juice Break Energizer
Hunt Hall Galley	10:30-11:15 a.m.	Change Process
Hunt Hall Galley	11:15-11:45 p.m.	**Comprehensive School Policy**
University Center	11:45-12:45 p.m.	Lunch
Quad II Galley	1:00-2:00 p.m.	Core Team/Student Closure*
Hunt Hall Galley	2:15-3:30 p.m.	**Evaluation/Action Planning**
Hunt Hall Galley	3:45-4:30 p.m.	Take Care of Yourself!
Hunt Hall Galley	4:30-5:00 p.m.	Closure

*Indicates Large Group Presentations which are with the student group. Large Group Presentations are indicated in bold type.

explore concepts and practice new skills.

Mini-Training and Program Sharing Conferences are one-day programs at which 100 to 200 students and advisors share action plans and successful program activities.

Structural Framework for Networking and Collaboration: Methodology and Content

As previously noted, the methodology and the underlying philosophy that make the UPTLP effective as a youth prevention program also make it an effective vehicle for networking and coalition building among individual adults and agencies.

Systems and Process Thinking

UPTLP provides a structural framework for a systems perspective that encompasses the entire UP. The ability to view the UP as a suprasystem encourages agencies and community members to collaborate and network more closely in a common effort to make human and financial resources stretch further. The network includes professionals from all areas of substance abuse prevention, intervention and treatment services, education, mental and public health, social services, and the judicial system; parents; and community members.

Positive Visions

The UPTLP provides a foundational philosophy that helps keep the focus on one positive, shared vision: *what we want for our youth*. This positive vision of common goals and teamwork is nurtured and reinforced at all trainings.

Personal Learning and Growth

The structure and content of the trainings foster meaningful personal and professional growth for the participating adults. Beginning and advanced adult trainings include "Comprehensive K-12 Student Assistance Training," "Crisis Response Debriefing," "Facilitator Training," "School-Based Intervention," "Personal Wellness Weekend," and "Program Sharing Workshop."

Many of the adults who attend trainings or work as facilitators at the UPTLP also hold positions in schools and agencies, such as treatment centers and mental or public health clinics. As a result of the personal and professional growth they experience at the trainings, they bring increased levels of personal commitment and strengthened abilities in communication, trust, problem-solving, and negotiation back to their roles in the interagency network. The student and adult trainings provide a common educational and philosophical basis that helps encourage and equip diverse groups of people to cooperate as an aligned team working toward a shared vision.

Sense of Community and Team

In much the same way that a regional peer group develops among the teen leaders, a sense of community and team develop among the adults who participate in and staff UPTLP trainings. Professionals and community members who may have formerly found themselves at odds, perhaps in competition for funding, are much more likely and able to collaborate on win/win solutions when they see themselves as members of the same larger community and team. As with the youth, authentic communication and the development of personal relationships constitute determining factors in the creation of a sense of community. Again, the relationships depend on knowing and caring about others both as individuals and as colleagues.

Mental Models

It demands great trust to set aside a mental model of "how things are" or "how things are done" and to really examine a situation through the eyes of another person or agency. When individuals identify themselves with a team of people they trust, respect, and share a vision with, their ability to suspend preconceived ideas and mental models is much greater. A team or network must achieve a level of trust before it can successfully use its resources to transcend individual and group mental models and seek new and creative solutions.

Prevention Program: Findings And Conclusions

According to process evaluations of trainings and the subjective feedback of parents and school and agency professionals, the UPTLP appears to have had a strong impact on students. Staff feedback indicates that adults have also benefited greatly from the program. As a result of the trainings, both teens and adults have made major changes in their lives, such as quitting smoking or seeking treatment for chemical dependency.

On average, between 3 and 15 referrals are made at each weekend- or week-long training. Referrals to Protective Services are among the most common. Students are also referred

regarding chemical use, suicide risk, and eating disorders. UPTLP staff provide followup to students, parents, and agencies, as necessary.

A followup evaluation of a PIP-Fest Weekend, conducted by the Substance Abuse Coordinating Agency in Ypsilanti, indicates that after a 6-month period, the majority (79 percent) of the students who participated in the PIP-Fest "believed they experienced a turning point during the weekend" that resulted "in a behavior change."

A formal evaluation of the UPTLP is currently under development. It will be conducted at four pilot sites and will measure the behavioral impact of the Teen Leadership Program as well as possible changes within the school climate.

Program strengths consistently mentioned in evaluations include a strong staff of skilled and caring adults; the creation of a safe environment where people can be "real;" and opportunities to learn about oneself and others, make new friends, and have fun! Students and adults also consistently identify the small skill groups as a critical component of the training experience.

A committee composed of adults and students from across the UP is currently evaluating ways to improve and expand the program. Possibilities include the provision of more extensive followup and support for students in every school and community. The level of involvement and support provided by the identified school contact person varies from district to district. Although staff and network members of the UPTLP are available to all districts and communities for support, presentations, and inservice trainings, not all districts have availed themselves of the services. In addition to some new types of weekend trainings, possibilities for new parent and community service components that enhance teen linkages to families and communities are currently being explored.

Structural Framework for Networking and Collaboration: Findings and Conclusions

The UPTLP currently has seven financial cosponsoring agencies: the Substance Abuse Prevention Program (SAPE-UP) at the Marquette-Alger Intermediate School District, which coordinates the program; both UP substance abuse prevention coordinating agencies, all three Michigan Model Comprehensive School Health Programs of the UP; and Northern Michigan University. Numerous other agencies (such as Community Mental Health and Department of Social Services) and local school districts provide staff for trainings and scholarship money for students.

Recognition is also due the Partners Institute and PIP-Fest, Inc., both of Minnesota. Much of the training methodology and philosophy used by the UPTLP originated with these programs. The UP coalition network continues to include a number of these program professionals from Minnesota and has even added a few members from Wisconsin and Canada. Their involvement has added a healthy outside perspective and fresh energy.

Approximately 6 years ago, student assistance programs began to pick up momentum as a viable means of providing comprehensive prevention, intervention and referral, and aftercare support services to students and families. An aligned network, with a history of successful interagency collaboration to draw upon, was already in place. It helped to provide trainings, technical support, and funding to school districts throughout the UP. This contributed greatly to the professional community's ability to respond quickly to districts' needs to develop and implement student assistance programs.

The UPTLP has proven extremely effective as an organizational structure that provides an avenue of involvement, shared leadership, and recognition to a diverse and geographically dispersed group of individuals and agencies. The network is not perfect. There are still gaps, challenges, and occasional areas of resistance. However, the members of this network provide a great deal of support to each other. They remain extremely committed to addressing the problems and improving the availability and quality of substance abuse services in the UP. They also recognize their place in a much larger system and realize that their ability to fill in the gaps and meet the challenges is part of an ongoing process.

Recommendations

The UPTLP provided an initial structure to organize a diverse group of stakeholders into a functional network. The nature of its programmatic philosophy and training strategies encouraged the development of systems thinking, provided positive vision and personal learning, suggested alternatives of new mental models for seeing and doing things, and promoted a sense of community identity among participants. The work of Peter Senge has been very helpful in understanding reasons why a strong, collaborative network of professionals and community members seemed to

simply emerge as a natural result of cooperating on the program. The answer lies partly in the fact that the five disciplines identified by Senge as essential for the establishment of an aligned learning team are also at the foundation of effective prevention programming. The UPTLP incorporated all five disciplines without having any conscious awareness of their potential power to foster the development of such a strong and expansive network.

Because these five disciplines have been shown to be effective in building collaborative networks and teams, they are being used as the methodology for working with a committee of 50 stakeholders involved with student assistance across the State of Michigan. This committee includes representatives from such diverse groups as the Office of Drug Control Policy, the Department of Education, the Department of Social Services, Community Mental Health, the Center for Substance Abuse Services at the Department of Public Health, Michigan DARE, Michigan PTA, school administrators and teachers, counselors, and student assistance trainers. It has undertaken two tasks:

1. To produce a guidebook of recommendations and guidelines for conducting Comprehensive K-12 Student Assistance Trainings (i.e., how do you bring together diverse groups of people from schools and communities, each having their own perspectives and concerns, and help them become aligned teams that can develop and implement effective student assistance programs?).

2. To facilitate a closer alignment of agencies at the State level. The underlying belief holds that for student assistance programs to really make a difference, they must represent a collaborative effort that incorporates all relevant agencies and networks, educators, parents, and community members into an aligned team. This process of alignment has a strong chance of successful replication within each community only if it is first modeled and strongly supported by agencies at the State level. This project has become known as "Crossing the Bridge" and is still in its early stages. However, it holds great promise and has generated a lot of energy and hope within the committee.

Since its beginnings 9 years ago, the UPTLP has provided many valuable lessons on effective prevention and early intervention and networking. Perhaps the most significant lesson teaches that good design and content are not enough. Ultimately, it takes good people and relationships to make good programs. This also holds true for developing an interagency coalition or network. In the building of truly functional, collaborative networks in rural and frontier areas, the primary investment of time and energy must go into developing human resources and relationships; problem-solving and the creative identification of financial resources will follow.

Specific recommendations arising from the experience of UPTLP include the following:

- Identify a shared area of concern and a programmatic concept that can serve as a structural framework around which to organize. A variety of programmatic concepts could function as the UPTLP did to provide a structural framework and focal point around which to rally.
- Create opportunities for stakeholders and potential network members to participate in shared learning and training experiences that incorporate the five identified disciplines. It is important that these opportunities be part of an ongoing process of professional and personal development. It can be very helpful to enlist the objectivity and neutrality of an "out-of-system" trainer who has strong process and facilitation skills. Small group process time, which allows participants to integrate information, share relevant personal and professional concerns and ideas, and get to know each other, serves as a key component.

In addition to helping build a common philosophical and informational base from which to work, the trainings also provide an opportunity to gain necessary skills and learn how to use the five identified disciplines. When used together as conscious methodology, these disciplines seem to have a synergistic effect: systems and process thinking plus personal learning plus mental models plus sense of community equals aligned teams and reduced levels of fragmentation. Reduced levels of fragmentation equal more effective use of human and financial resources; more support; and effective prevention, intervention, treatment, and aftercare support programs.

Collaborative networks help reestablish and strengthen linkages between individuals and organizations. They are effective because they capitalize on the fact that all of us, together, know more and can do more as cohesive members of an aligned team than any of us can do alone, providing fragmented services as individuals or agencies. Furthermore, networks empower individuals and agencies; they offer opportunities for shared input, shared decisionmaking, shared responsibility, and shared recognition. Everyone wins—especially our youth!

You Can't Get There From Here: The Choice/Skyward Experience

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This paper focuses on a program that was near collapse, the strategies that were employed to build coalitions, and the changes that occurred in the delivery of service. The initial consensus was that this was an impossible task. But, by using the program philosophy, being aware of personal and program boundaries, and engaging both the recovering community and service communities, the agency and services were revamped and revised.

Introduction

Choice/Skyward is a publicly funded outpatient substance abuse treatment agency located in the small community of Rockland on the coast of Maine. We are the only licensed facility in Knox County, which covers 374 square miles and has a population of 37,000. The population doubles during the summer months. Included in the county are the six island communities of North Haven, Vinalhaven, Criehaven, Matinicus, Monhegan, and Isle Au Haut. These islands lie anywhere from 12 to 20 miles offshore. There is daily ferry service, as weather allows, to North Haven and Vinalhaven. The farther island communities such as Monhegan and Matinicus must be accessed by mail boat, if space and weather allow, or by private plane by those with more resources.

Knox County is one of the poorest counties in New England and maintains an average unemployment rate of 10 percent. In the last 4 years, the State of Maine has suffered particularly hard financial times and social services have been a leading target of budget cuts. Consequently, the needy in Knox County have felt the harsh realities of the scaling down and, sometimes, the loss of badly needed support services.

The closest detoxification and inpatient treatment programs are located 45 and 75 miles away, respectively. Many of the clients seen by Choice/Skyward for treatment have low income. The only inpatient program in the State willing to serve these clients is located 70 miles north of Rockland, and the closest intensive outpatient/day treatment program is located 75 miles west of Rockland. Needless to say, access to these services can pose a formidable problem.

As a result of Maine's stringent drunk driving laws, many of Choice/Skyward's clients are sent for treatment after they are convicted of operating under the influence. Nearly all of these clients have lost their driver's licenses for a period of at least several months. Consequently, in an area where access to services is already limited, and public transportation is nearly nonexistent, compliance with the requirements of the court seems a heroic matter.

Three years ago Choice/Skyward found itself facing the following problems:

- A very fragmented support system for recovering persons
- Very limited public transportation
- Clients who traveled long distances who might have to wait hours for a ride or a ferry home
- No detoxification services available in the county
- An agency budget about to be cut by at least one third. (This budget was in fact cut by two thirds.)

It was clear that our strategies for service delivery needed to change and that the community needed to be involved if we were to be successful in building a continuum of care. The staff and the Policy

Council met to formulate plans to revitalize and reimagine ourselves and our services. It appeared that given our circumstances we "couldn't get there from here."

Choice/Skyward's problems affected both consumers and the community at large. If Choice/Skyward were to remain a community-based program, it needed to find solutions within the community; professional solutions would only serve to further distance it from the community. The recovering community was our primary focus. Furthermore, both the community at large and the recovering community have the capacity to respond quickly and decisively to problems, since they are not encumbered by institutional interests such as budgets, by-laws, etc. Choice/Skyward needed to use this responsiveness and energy as a positive force for change.

At the same time, the hospital community needed to be engaged in the process of finding a solution to the lack of detoxification services and the nonexistent continuum of care. As the only hospital in the county, they could act as a major influence and source of education for physicians and other health care professionals.

Choice/Skyward believes that the services we provide are supported and used by the community and, therefore, the community must take part in defining these services and determining how they will be delivered. We are aware that professionalized service can be disabling to community members. This awareness can help ameliorate the iatrogenic effects of treatment (Illich and McKnight). This philosophical stance has helped us keep our focus and sustained us in the belief that we could get where we wanted to go, although it appeared there was no road.

The Recovering Community

The recovering community was approached by every member on staff. People from every Alcoholics Anonymous (AA) group in the area were invited to a meeting to discuss the problems of recovering people in our county and the possibility of using Choice/Skyward space for a recovery club. Five people attended the meeting. They were acutely aware of the lack of detoxification services and the lack of access to treatment services. They had suspicions regarding the services we provided and felt discouraged that there was no "central place" for members to gather just to socialize or "have a cup of coffee."

AA members also brought to light some of the recovery problems experienced by people working on fishing boats. Many of these individuals are out to sea on small vessels for 2 weeks or more. Any services they receive must have flexible schedules. The island populations also had difficulty accessing services because of transportation problems.

The group members were impassioned in their responses. They very much wanted to help find solutions to problems faced by the agency and by people early in recovery. They felt that this would be more possible if they had space for a recovery club. Space is an asset Choice/Skyward had available.

Choice/Skyward offered the basement floor of our building to the recovering community. It is a 3,000-square-foot finished space with bathrooms, kitchen, and two entrances. We proposed that this space be used in any way the recovering community liked. Choice/Skyward did not want any control over the decisions that would be made. The recovering community would have to comply with city regulations and keep noise down during Choice/Skyward's hours of business.

This group then began to meet without Choice/Skyward and developed a plan for the space by working through all the AA groups in the county. The plan presented to Choice/Skyward proposed using the space for a club that would be open from around 8 a.m. until midnight. It would be managed by a Board of Directors made up of members from various AA groups. They wanted to have a person in charge present at all times. They wanted to create a safe place where people could drop in for coffee, play a game of cards, read the paper, receive a little reassurance, attend daily noon meetings, wait for or find rides, etc.

Choice/Skyward agreed to their proposal, and the club received 1 year's free rent. At the end of 1 year, a rental agreement would be negotiated.

The club's progress was remarkable. Within 3 months, the space was painted and furnished with donated furniture. They installed a pool table, cable TV, and a coffee service; subscribed to the local papers; and held regular weekend yard sales of donated goods. A volunteer manager staffed the club at all times. They began to plan dances and other recreational events. From the day they received the keys until the present, a daily AA meeting has been held.

The response from the community was overwhelming, and celebration was in the air. After the initial 3 months, the club approached Choice/Skyward to propose that they do more for the treatment program in exchange for the space. They began a fund to provide transportation to detoxification and inpatient treatment centers around the State. They then organized drivers to provide the service.

As the first anniversary of the club approached, we began the process of negotiating a lease. The survival of the club was Choice/Skyward's agenda. The club had provided our clients with transportation to services, an introduction to AA and recovery that went far beyond what most treatment centers can offer, a fun and energizing place to wait, and the message that recovery is possible.

It also brought to staff meetings and to Policy Council/Board meetings some of the complaints that the community had with the treatment program. The program responded by changing service delivery times, the configuration of the groups, billing procedures, and staff.

The second year lease was negotiated, and the club agreed to pay $50 per month rent, handle trash removal for the entire building, mow the lawn, and provide snow removal. In addition, it volunteered outside of the lease to continue providing transportation services for our clients and to work on improving the AA hotline and institutional committee. Both the lease and the informal agreement continue to this day.

The Hospital

We approached the hospital community in two ways. First, we discussed the problems with our medical director and asked him to speak for us to physicians. Then we approached the manager of the psychiatric unit at the local hospital, who had expressed an interest in our program and in services for recovering persons. We were able, through the psychiatric unit, to renegotiate a contract for consulting services to be made available to all the units at the hospital. We also agreed to work together to find funding to expand services in our community.

The Choice/Skyward staff became a regular presence at the hospital. The different hospital units quickly discovered that the consultations they ordered had an impact on patients and that we were able to connect addicted persons with a variety of recovery programs.

The emergency room hired a new director who had been trained in substance abuse and called us regularly concerning addicts who came to the emergency room. We provided the hospital with the number of persons we saw over a period of time who needed detoxification but who had to be referred outside the county, when they could have been better served here in their home community. The hospital used these figures to support a certificate of need for detoxification beds.

Our hospital meetings moved to a different level when we met with the hospital president, board president, fiscal representative, and psychiatric unit manager. With the hospital's assistance, we were able to submit a proposal to the State for stable funding for our program. This proposal was written collaboratively and funded by the State of Maine.

The hospital received approval for their certificate of need and planned for a building which would include detoxification beds. We dreamed of expanding and collaborating in other ways in order to create a continuum of care.

During this period of time, we worked on a collaborative grant that also included the local mental health center. We proposed to provide education to the community and professionals on dual diagnosis. We also proposed a collaborative board made up of all services and segments in our community to find solutions for our dually-diagnosed citizens. We won the grant.

Our medical director spoke individually with most of the physicians in our community. He created a broad base of support among physicians which resulted in many new referrals to Choice/Skyward. Many of these referrals were covered by third-party payors and thereby increased our revenues. The director was also willing to staff cases with us when there were questions regarding prescribed medications, and he intervened with physicians when prescriptions seemed inappropriate. Through his efforts, the trust level between Choice/Skyward and individual physicians grew.

The Results

We are well into our third year of building coalitions and creating strategies for improved service delivery. The Choice/Skyward program has changed in many ways. We listened, although at times it was painful, to the complaints and suggestions from the community. It became clear that over a period of time that saw many changes in personnel, the Choice/Skyward program had become self-centered; many times staff members had taken the position that when it came to recovery, we knew best. This conveyed the message that a client could truly benefit only from professionalized help, which counters everything a person learns in AA.

Staff members revised operations with the help of the community. We saw and felt the community's power and sensed respect for the part we played in it. We experienced a sense of relief; we did not have to have the perfect solution to anything. Staff gained visibility, Choice/Skyward's revenues increased, and we grew

more willing to try new configurations.

We saw some clients every day for 15 minutes and others for 2 hours. We worked on delivering the service in the most acceptable and appropriate way for each client and changed the way we staffed our program.

The recovering community's support of this program continues to increase, and the club continues to prosper. Over time it has had its ups and downs, but Choice/Skyward has always kept the boundary firm and reserved comment. Had we interfered, we believe the club would have failed. The recovering community prides itself on its success and its ability to solve problems. They also take pride in having reassumed their responsibility to people trying to recover from addictions.

Our relationship with the hospital continues to grow and now includes the mental health network. Over the past 2 years, the hospital has done some detoxification on an informal basis. They have also been willing to monitor patients medically while we make arrangements for transfer to detoxification and inpatient treatment. This has been a much more formal process than what we experienced with the club. We were much more aware of the chain of command and the many layers of decisionmaking that needed to be included.

At this time in our collaboration, there are plans to open an expanded mental health unit which would include detoxification beds, outpatient detoxification, a special track of services for addicted patients, day treatment services, and an intensive outpatient program.

Although it was said many times "you can't get there from here," we did it. We made it because of a willingness to change, to engage the recovering community and the service system, and to work at keeping clear boundaries between ourselves and others. We saw the possibilities as greater than the problems. We can truly say that we are a community-based program providing services that the community itself has requested and finds valuable. The test over time will be to remain flexible and open to the voices of wisdom in our community.

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School Teacher's Role in a School-Community Alcohol Intervention Program

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Because the majority of rural and/or frontier children attend school for at least some time in their lives, implementing a low-cost, school-based alcohol and other drug prevention and intervention program is an effective way to reach a majority of children with alcohol and other drug abuse prevention, education, and early intervention services. This paper describes a model program, the School-Community Intervention Program (SCIP), and describes the results of a 2-year evaluation of 35 schools.

Purpose

Adolescent alcohol use continues to be a primary concern for both school personnel and community members. The Monitoring the Future Survey estimates that 90 percent of high school seniors have used alcohol at least once in their lifetimes, and 32 percent report consuming five or more drinks in a row in the 2 weeks before the survey (Johnston et al. 1991).

The rural and/or frontier areas of the United States are not exempt from adolescent alcohol and other drug use. Newman and Anderson (1989) studied adolescent alcohol use in the midwestern State of Nebraska and found that 45 percent of 18-year-old male high school students and 30 percent of 18-year-old female high school students reported consuming five or more drinks in a row at least once in the previous 2 weeks.

In response to concerns expressed by school administrators, parents, and community members about adolescent alcohol use, a medical service organization (the Lincoln Medical Education Foundation) developed a program to help schools deal with student use of alcohol and other drugs. The program is based on the assumption that failure to perform adequately in school is a possible indicator of (1) present use of alcohol and other drugs, or (2) an increased risk of future alcohol and other drug-related problems. This program is called the School-Community Intervention Program (SCIP).

Method: SCIP

The SCIP has five stages, including: (1) identification and training of a SCIP team; (2) identification of students with academic and/or behavioral problems; (3) intervention on behalf of selected students; (4) education/prevention; and (5) community liaison.

A typical SCIP team in a participating school consists of school representatives (teachers, counselors, and administrators), trained to identify students who are experiencing difficulty at school, who intervene and provide support for the student and his or her family. Students exhibiting

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difficulties in school are referred to the SCIP agencies. Families are given the opportunity to obtain services from the school or from community agencies to resolve problems.

SCIP team members receive 4 days of intensive training to prepare them to assist referred students and their families. This training provides information on values, attitudes, and beliefs about alcohol and other drug use; pharmacology; family dynamics; enabling; identification of at-risk students; intervention techniques; implications of various school policies for chemical use; and techniques for building effective community-school liaison.

The number of people on a SCIP team may vary according to the size and needs of the schools, as may the number of SCIP teams in a school. Most teams have an administrator, a counselor, a school nurse, and one or more teachers. Currently, SCIP teams reflect the following distribution of personnel: teachers, 60.1 percent; counselors, 15.9 percent; administrators, 15.9 percent; nurses, 8.2 percent.

After a student is referred to a SCIP team, all faculty who have contact with that student are asked to review the student's behaviors. This review focuses on the following areas:

- **Classroom conduct**
  - Disruptiveness in class
  - Inattentiveness
  - Lack of concentration
  - Lack of motivation
  - Sleeping in class
  - Extreme negativism
  - In-school absenteeism
  - Tardiness
  - Defiance
  - Cheating
  - Fighting in class
  - Verbal abuse
- **Family concerns**
  - Mentions alcohol or drug abuse
  - Speaks angrily of parents
  - Suffered recent loss (such as move, divorce, or death)
  - Other siblings' problems
- **Academic performance observed**
  - Declining quality of work
  - Incomplete work
  - Declining grades earned
  - Academic failure
- **Appearance and health**
  - Neglected personal appearance
  - Bruises
  - Bloodshot eyes
  - Continual undiagnosed malady
  - Coloration (pale and flushed)
- **Other school conduct**
  - Unexcused absences
  - Frequent absenteeism (even if excused)

Through a review of these characteristics, school personnel can identify students who are exhibiting behaviors that interfere with their ability to learn and succeed at school. Experience has shown that these behaviors are frequently related to the student's or a family member's use of alcohol or other drugs.

After the student has been identified and the teachers have documented the school behaviors that are of concern, the SCIP team conducts an "intervention" with students and their parents. At the intervention, the behavior of the student is described, the parents' cooperation is sought, and a plan is developed to improve the student's behavior and increase the student's opportunities to succeed in school. This plan may include, but is not limited to, a referral to a school resource person for further family assessment, a referral for academic assessment, or continued monitoring of the offending behavior within the school.

The SCIP team is trained to identify students experiencing difficulty which may be related to the use of alcohol and other drugs by recognizing unusual student behavior, but the team does not draw conclusions that this behavior is caused by drug and/or alcohol use. School staff members identify problem behaviors; they do not label or diagnose. When appropriate, school staff members refer students for special services.

The intervention process is the most sensitive aspect of SCIP. The intervention process must be case specific and well planned. Its aim is to assist students to identify and modify behavior to reduce the risk of school failure. This process alerts students that there is a defined attitude of caring within the school and provides teachers with a systematic and specific vehicle for obtaining help for troubled students.

Schools do not provide treatment for students and families experiencing alcohol and other drug problems. However, SCIP teams do actively maintain two-way communication with cooperating treatment agencies in the community. Agencies are asked to secure a release of information from the participating school when the agency evaluates or admits students to treatment.

Postevaluation and/or treatment support is essential for those students who have been assisted by SCIP if they are to maintain alcohol-free and other drug-free lifestyles. The focus of the support component is to help troubled students to establish relationships with others and to learn the constructive use of free time. The focus is not to deal with issues from treatment, rather the goal is to assist the students and their families to move beyond the treatment process toward a successful school experience.

Followup support for students is made available through support groups aimed at increasing the students' skills to overcome difficulties. The support groups are staffed by SCIP team members who continue to monitor student

progress and assist them as necessary. This process provides the schools with an additional avenue to aid students in the successful completion of their schooling. The presence of a comprehensive program in schools furthers the message to students that they are supported to remain drug- and alcohol-free.

Schools are a reflection of their communities. As a result, the SCIP process establishes a school-community task force consisting of school personnel and a number of local community leaders. The school-community task force is an integral part of the SCIP process and is the vehicle for a school-community partnership to address the multifaceted dimensions of adolescent substance use. The assumption is that adolescent substance use is not solely an individual or family phenomenon but reflects community values, attitudes, and beliefs.

Ideally, this task force is made up of representatives from the law enforcement system; the judicial system, including probation, alcohol, and other drug treatment and health care agencies; social services; the business community; service organizations; and the schools. Open communication between school and community members leads to the understanding that adolescent alcohol and drug use is not solely a school problem.

Findings

In Nebraska, 171 SCIP teams have been trained to serve in 63 schools. Originally, the project included only junior and senior high schools, but recently a large number of elementary schools have joined the program.

On average, 7.5 percent of a school's students were referred to SCIP over a 2-year period. Of these students, 22 percent received professional evaluations from nonschool sources, and 78 percent received other support services. Of the students who received professional evaluations from nonschool sources, 63 percent entered formal treatment programs, 6 percent were assisted by in-school sources, and 30 percent did not enter any formal treatment program.

The 57 percent of students referred to SCIP who did not receive professional evaluations were monitored and assisted in their schools by the SCIP team. Twenty-six percent received special school services, and the remaining 17 percent quit school, received no followup, or received other forms of assistance. Typically 60 percent of the referrals were male and 40 percent were female.

Schools in Rural Communities

Thirty-five schools with SCIP teams in 23 rural communities were closely monitored over 2 years as part of an evaluation of this program. In these schools, 7 to 10 percent of the student population were identified as experiencing academic and/or behavioral problems and were referred to a school SCIP team for assistance. Of this number, one-third were identified as experiencing behavioral, medical, and/or psychological problems not related to the use of alcohol and other drugs. These students were channeled to appropriate community agencies or received in-school help.

Two-thirds of the students referred to SCIP teams were experiencing problems related to use of alcohol and other drugs. One-half of these students and their families needed assistance from community chemical dependency services in the form of formal evaluation and/or treatment. The remaining one-half needed school-based early intervention, education, and family support. For many of the students and their parents in this latter group, the identification of a problem by the school, the expression of care and concern by the SCIP team, and the active problem-solving involvement before problems become long-term resulted in positive behavior changes. The behavior changes were self-reinforcing, and the early intervention was successful in preventing more serious problems.

Differing Intervention Patterns

Two patterns of implementation and/or intervention have emerged in SCIP schools over this 2-year period. The differences were related to school size. The area where the project was developed and conducted was largely rural. School sizes varied, with the larger schools enrolling 210 or more students in grades 7 through 12.

Smaller schools reported a more informal, initial pre-referral data-gathering process. This process involved rumors, weekend reports, history from medical records available to the school nurse, nonprofessional personal contacts with families outside of the school setting, and behavior problems of siblings. Identification of any of these problems was considered appropriate for a SCIP referral. At that point, the team proceeded to contact the student's teachers for specific documentation, or the school counselor talked to the student directly. Smaller schools called this an "early diversion process."

In the larger schools, informal sources of information were not used as a basis for a referral, and no formal contact occurred until all SCIP reporting forms had been returned by the teachers. In the larger schools, rarely was there a

direct intervention with a student alone. A student would be contacted only after the team had intervened with the parents.

As the SCIP teams matured in their roles, they adapted the process. Larger schools developed a formal feedback process to teachers to thank them for the referral and for documentation. SCIP teams also developed a feedback process to parents, especially for students who were being monitored, to let them know how the student was behaving in school.

Both small and large schools reported that teachers were more proactive in the classroom with students who had been through the SCIP process. This reaction is seen as a positive result of the program which arose from acceptance of the SCIP process as a rational approach to the problem of educational failure and adolescent substance use. There has been generally increased staff awareness of what behaviors indicate problems or what behaviors might be a positive effect of an early intervention. Most of this awareness has occurred through the informal sharing of experiences and the increased involvement of school personnel in SCIP.

The development of school-community task forces required a commitment of time and energy. In the communities where this commitment has occurred, the benefits have included more effective working relationships with community agencies, law enforcement, and community service groups. However, full implementation of this part of the program remains a challenge.

While SCIP appears to focus on early intervention, its presence has a profound effect on behalf of prevention. Teachers and community members become more aware of the alcohol and other drug problems in their school and community and begin to support and encourage more prevention activities, such as improved school curriculums, support for alcohol-free entertainment, and stricter law enforcement.

The most global measure of success of SCIP involves student self-reports of alcohol and other drug use. In carefully conducted annual surveys, among other activities, students were asked to identify where they learned the most about alcohol and other drugs. They were also asked to record their alcohol usage over the past month and over the past year, whether they had consumed five drinks in a row in the past 2 weeks, and how often they consumed alcohol to get high.

Table 1 reports the results of these questions in two groups of schools. Seven schools are included in the group that has had an active SCIP for 2 years. Six schools are included in the group without such a program. These schools were comparable demographically. More students in the schools with a SCIP program reported learning "the most" about alcohol from the schools as compared with parents, television, friends, or other sources. More importantly, those students reported less use of alcohol on several measures. On all variables, those students who reported learning the most about alcohol from the schools also reported less

Table 1
Comparison of Schools With SCIP and Schools Without SCIP

Variable	Students of Schools With SCIP (*n*=1,321) Percent	Students of Schools Without SCIP (*n*=1,272) Percent
Learned the most about alcohol from schools	31.9	24.1
Used alcohol to get high	40.9	44.7
Consumed 5 drinks in a row within the last 2 weeks	26.8	29.5
Did not drink within the past month	52.3	52.6
Did not drink within the last year	32.6	31.3

usage whether their school had a SCIP or not ($p<0.000$).

Conclusion

As a result of SCIP, there appear to be new attitudes of caring about adolescent use of alcohol and other drugs in schools and communities. The impact transcends immediate identification of students in difficulty. Teachers and administrators are clearer about their expectations for students relative to alcohol and other drug use, and they report a high degree of satisfaction with SCIP. Both teachers and administrators have new alternatives to use as they address the problems of substandard academic work and problem behaviors. Community and school representatives are beginning to work together in the development and implementation of more systematic approaches to helping students, while teachers report that student problems related to the use of alcohol and other drugs are now addressed, whereas before they were often ignored.

Recommendations

Because most rural children attend school for at least some time in their lives, implementing low-cost alcohol and drug prevention and intervention programs in elementary, junior high, and high school will reach the majority of rural and/or frontier children. SCIP is inexpensive to start up and maintain, requires no hiring of extra staff, and interferes very little with the primary functions of the school teaching and learning. SCIP is unusual because it ties prevention activities directly to a student's academic performance. Expansion of this program to other rural and/or frontier schools is desirable.

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Challenges in Rurally Based Alcohol and Drug Abuse Treatment Services

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This paper describes alcohol and chemical dependency treatment needs in a sparsely populated area largely consisting of casino employees and their families. The area also contains many retirees who come because of the climate and the casino environment. In addition, the area attracts water sports enthusiasts and campers because the Colorado River separates Bullhead City, Arizona; Needles, California; and Laughlin, Nevada. As a result of these factors, the community population triples on weekends from October to May. Vacationers from all over the United States, mostly retirees, bring recreational vehicles and relocate here for the winter months.

When these people need treatment for alcohol and chemical dependency, support groups and professionals from their home communities must be contacted for referrals. For this reason, a directory of substance abuse resources in rural areas is needed.

When I first relocated to this area, there were few professionals in our field, and most of the population had to go 100 miles to Las Vegas for inpatient or outpatient treatment. Therefore, a treatment center was started to provide treatment modalities needed in this environment. This area is growing quickly and, as casinos open (there are now 10 casinos, and they are rapidly expanding), new employees relocate from larger cities where all treatment components are usually available.

Step 1: Determining Need

Because of the rapid population growth, I persuaded the firm in Riverside, California, in which I was serving as Treatment Program Director to allow me to return here (it is my home community) to conduct a community needs assessment. I did the assessment by contacting casino management, community resources, and insurance companies. Because of the assessment's initial results, the Bullhead Community Hospital committed to providing some office and treatment space.

After 6 months of taking phone calls and making assessments, I determined that an intensive outpatient substance abuse program was needed. The program required patients to attend Monday through Friday for 3 hours a day for 4 weeks. Any patients needing inpatient detox or rehabilitation had to be referred to Las Vegas, although many patients were detoxed by our program's Medical Director on an outpatient basis.

Step 2: Expanding Services

After 1 successful year, I found that many people needed inpatient detox services. Therefore, I developed policies and procedures for starting a six-bed detox unit in our small community hospital. The unit was licensed by the State on January 3, 1993.

Because of the community's needs, I will focus next on developing policies and procedures for licensing an inpatient rehabilitation program. My experience with such programs has shown that it is better to go "one step at a time" and to make each modality successful before considering opening another. Marketing the program and contracting with insurance companies is done by me.

Of course, the program will rarely be able to refer patients for mental health issues because of the limited number of mental health professionals in a small community like this one. Being the only structured program in the Tri-State area, we provide services for Needles, California; Laughlin, Nevada; and Bullhead and Kingman, Arizona. Many of our referrals come from Employer Assistant Professionals, health management companies, and the small community hospitals in these cities.

Meeting Special Population Needs

The substance-abuse population here is different from that of other small communities, since the explosive growth has brought a new population that work in casino environments. Of those in this group who use drugs, most have a drug of choice. The most predominant drugs here are speed, marijuana, and alcohol.

Compulsive Gambling Problems

The area's other unique characteristic is that a large percentage of clients seen here also have gambling problems. Most often, we are treating compulsive gambling in addition to dual drug addictions.

The casino environment, in which alcohol and gambling are readily available 24 hours a day, affects families. A large percentage of both husbands and wives work in casinos (often on different shifts); therefore, the children of this population suffer the most ill effects.

Program for Children

Children have a great deal of unsupervised freedom, causing increasing drug problems in our schools. One solution to this problem has been to contract a licensed child psychologist, employed by the local school district, to assist the children of adults in recovery. This program is structured to help all members of the patient's family.

In 1992, we had our first Christmas party for patients who have graduated from the program and have remained clean and sober. While some graduates could not attend because of work schedules and some attendees were family members rather than graduates, we had 70 positive RSVPs to this event. This attendance speaks for the program's success.

Principles of Successful Treatment

However, this program does not conclusively answer many of the deeper problems that cause substance abuse. Possibly 80 percent of those who live here came from other areas. Many of them leave their hometowns to get away from the drug environment. They do not realize that they choose the environment; the environment does not choose them. Everyone grows up with different values and personality traits; in recovery, these must change. For each substance-abusing person, we need to find the cause(s) of their abuse. For a large percentage of our patients, it began with physical, sexual, or verbal abuse by relatives or friends, which of course profoundly affects their self-esteem and ability to trust. They turn to alcohol and drugs to make them feel better and to mask their feelings, because they do not know how to properly deal with their feelings.

In cutting through the patient's denial of the addiction, the counselor has to deal with the denial of the cause. Many patients need to spend a lot of time with the counselor to create enough trust to be honest about their feelings—one of the most important phases of recovery.

Successful treatment programs are founded upon a variety of concepts. In my 17 years of experience, the most important factor has been to hire employees who are knowledgeable, compassionate, and understanding of the patient's problems, but are also assertive enough to tell them what they need to hear to help them and their families through recovery. It is also important to create a treatment program that focuses on the population's needs and to be willing to change the program's components as the needs change.

Several measures are needed to reduce substance abuse. Education on substance abuse is required in schools so that abuse can be prevented or terminated early on. Individuals and employers need to be educated to identify problems that can lead to signs of substance abuse. Insurance policies or any future national health plan should provide chemical dependency coverage. State-funded programs need to provide continuing education on new techniques for professionals in this and other small communities to attract professionals to these areas.

Alcohol and drug abuse in this area has increased, not decreased. Street or prescription drugs can easily be purchased. The flow of drugs into this country must be stopped and requires more attention from the Government. If drugs become scarce, prices will increase, and they will become unaffordable for most people. Such a situation would remove many adolescents from the drug scene.

Are these the only solutions? No, but there are no perfect solutions. This paper is written on the basis of my experience in this area; the opinions expressed are based on the needs of people here.

Issues in Providing Alcohol and Drug Abuse Services in Rural/Frontier Counties of California

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During the Senate confirmation hearings for Donna Shalala, Secretary of Health and Human Services, an interesting discussion occurred between Secretary Shalala and Senator Baucus of Montana. This discussion alluded to a problem that underlies many of the issues confronting California's rural/frontier counties in providing drug and alcohol services to their constituents. Senator Baucus quite ably described the problem rural States face in providing health services under Federal regulations that do not differentiate between urban and rural States' health care delivery systems.

In response, Secretary Shalala acknowledged these problems and said she intended to avoid health regulations based on the premise that "one size fits all." Senator Baucus replied that there are many other "sizes" reflected in health problems across the United States and that no size should be overlooked.

Purpose

This paper addresses the issues encountered by one size of the alcohol and drug service delivery system—the organizations that provide alcohol and drug abuse services in rural/frontier counties of urban States. The problems and issues faced by service delivery organizations of this size are often overlooked by decisionmakers at the Federal, State, and urban county levels.

This paper describes the 19 counties in California that have the smallest populations. Each receives a minimum allocation of State and Federal dollars for alcohol and drug services. Key issues affecting these counties are delineated, and the counties' differences from and similarities to rural States are noted.

The issues discussed are the definition of "rural," leadership problems, and funding concerns. These issues do not address all of the problems facing rural/frontier counties in California, but were selected for discussion because of their resistance to attempted solutions over time.

For example, the funding criteria for Federal grants were identified as a barrier to obtaining funding in California's rural/frontier counties as early as 1976 (California Department of Health Services). Seventeen years later, the Federal funding criteria still make it difficult for California's rural/frontier counties to access Federal grant funds.

Overview of the California State Alcohol and Drug Delivery System

In the State of California, virtually all publicly funded alcohol and drug treatment, recovery, and prevention programs are planned, organized, and implemented at the county level. State law mandates that each of California's 58 counties appoint an Alcohol and Drug Program Administrator. Usually one person is appointed by the County Board of Supervisors to administer both the alcohol and drug programs. However, some counties (particularly urban counties) appoint separate administrators for each program. The county administrators have the following responsibilities:

- Management of the county level process for program planning and priority setting
- Administration of all Federal, State, and local public funds for alcohol and drug program services
- Consultation with the California Department of Alcohol and Drug Programs regarding statewide

program and fiscal policy, program regulations, and legislation

In the early 1970s, the California County Alcohol and Drug Administrators organized two associations to establish statewide forums that could discuss alcohol and drug problems and provide a single point of consultation for the California Department of Alcohol and Drug Programs. The California Association of County Drug Program Administrators was formed in 1973; 18 months later, the County Alcohol Program Administrators Association of California came into existence. The associations are currently holding joint meetings to explore merging into a single association.

Before they established these joint meetings, each association met quarterly. Each had a small and rural counties committee, the membership of which was loosely defined. California legislation provides for separate alcohol and drug services and defines small or rural counties differently for each. For allocating alcohol services, counties with total populations below 200,000 are considered small or rural; regarding drug services, counties with populations below 125,000 are considered small or rural.

These legal definitions continue to be reviewed by the associations and the Single State Agency (SSA). Moreover, in the past year, the associations have identified 19 counties with the lowest levels of funding as Minimum Base Allocation (MBA) counties. Consequently, their small and rural counties committees have been merged and renamed as the Minimum Base Allocation Committee, which serves both associations.

The MBA Committee is the culmination of many years of discussion regarding the definition of rural/frontier counties in California. This leads to the first issue to be addressed in this paper.

Defining "Rurality"

In 1976, small and rural counties in California began lobbying the California Department of Alcohol and Drug Programs to conduct a needs assessment of drug abuse problems in their areas. Originally, the 26 smallest counties were to be included in the Rural Drug Needs Assessment Project (RDNAP). However, at the insistence of urban counties with rural areas, a total of 49 out of California's 58 counties were included. This required that the contractor, California State University—Chico, devise a strategy by which counties could be clustered together based upon varying degrees of "rurality" (California State University—Chico, 1980).

RDNAP recognized that counties could differ significantly despite a shared rural designation. For example, Alpine County, with a population of 1,113, and San Bernardino County, with a population of 1,471,300 (90 percent of which is clustered on 10 percent of the county's land mass), are both legally defined as "rural" counties, but they differ greatly in geography, demographic characteristics, and culture. Therefore, RDNAP developed the concept of "rurality," based on a county's population size, population density, percentage of population that is rural, total area, and number of housing units.

Differences by "Rurality"

This concept enabled the project to identify each county in California as "very rural," "rural," "urban/rural," or "urban" and to compare indicator data and planning needs on the basis of rurality. Indicator data from both primary and secondary sources were found to differ significantly by this rurality, as did characteristics of program staff, demographics of clients in treatment, training needs, unmet needs, and fiscal resources. All the counties identified by RDNAP as very rural, along with the five smallest counties by total population in the rural category, currently make up the 19 Minimum Base Allocation (MBA) counties mentioned previously.

California's current allocation formula is based on a policy put forth by the counties and accepted by the SSA in the 1970s. This policy ensures that a minimum of "core" alcohol and drug services is available to all persons residing in California, regardless of the size of the county in which they live. The core services were originally established as prevention and outpatient services staffed by no more than 1.5 full-time employee positions: a half-time administrator and a clerical position. The number of staff has increased over the years as additional funding has become available in the State, but the definition of core services has only recently been reexamined. The MBA counties and the SSA are currently reviewing a study (completed in 1992) that attempts to redefine core services, based on the actual cost of services.

Definition of MBA Counties

The MBA counties are defined using only the fiscal allocation they currently receive. Consequently, four counties that meet the Federal definition of rural are not MBA counties because their populations are large enough to warrant a greater allocation than the current allocation formula gives to MBA counties. Furthermore, one mountain county (population 30,039) technically defined as urban is included as an MBA

county because its residents' location on a relatively small land mass distorts the population density.

With the exception of this county, the MBA counties meet the Federal definition of rural (fewer than 50 persons per square mile), with population densities ranging from 1.51 persons in Alpine County to 50.69 persons in Amador County. The population density for all 19 counties is 9.33 persons, which approaches the Federal definition of a frontier county (fewer than 6 persons per square mile). In fact, if the 5 most populated counties were removed, the remaining 14 counties would have a population density of 5.86 persons. The population density of California counties, and specifically the MBA counties, can be seen in figure 1.

The 19 MBA counties have a total population of 472,558 persons spread over a total of 50,626 square miles. This is a larger population than resides in the State of Wyoming and is not much smaller than the States of North and South Dakota.

There are several differences, however, between California's MBA counties and most rural States. These differences are

- The MBA counties are not contiguous but are spread across nearly the entire State.
- The largest city in the MBA counties has a population of fewer than 15,000 persons.
- There are no 4-year universities in any of the MBA counties.
- Most of the MBA counties are based upon single-season industries, such as tourism, agriculture, ranching, and logging, which results in high unemployment rates, large numbers of welfare recipients, and small tax bases.
- County Boards of Supervisors in the MBA counties are required to implement programs mandated by the State legislature and designed to ameliorate problems most often experienced in urban centers, regardless of local needs and available funding.

Figure 1
Population Density of the Base Allocation Counties

County	Population	Square Miles	Population Density
Alpine	1,113	727	1.54
Amador	30,039	601	49.98
Calaveras	31,998	1,036	30.89
Colusa	16,275	1,156	14.08
Del Norte	23,460	1,003	23.39
Glenn	24,798	1,319	18.80
Inyo	18,281	10,079	1.81
Lake	50,631	1,327	38.15
Lassen	27,598	4,690	5.88
Mariposa	14,302	1,461	9.79
Modoc	9,678	4,340	2.23
Mono	9,956	3,103	3.21
Plumas	19,739	2,618	7.54
San Benito	36,697	1,397	26.27
Sierra	3,318	959	3.46
Siskiyou	43,531	6,318	6.89
Tehama	49,625	2,976	16.68
Trinity	13,063	3,223	4.05
Tuolumne	48,456	2,293	21.13
TOTALS	**472,558**	**50,626**	**9.33**

Problems resulting from geographic isolation, lack of structural resources, and a rural culture that tends to support individual behaviors, including chronic alcohol use, has made it very difficult for drug and alcohol services to develop in California's rural/frontier counties. These problems are compounded by the lack of a consistent and realistic definition of rural/frontier counties upon which the necessary research and policy studies can be based.

Leadership Issues

California's inability to clearly define rural/frontier counties and to expand the limited resources available to these counties has resulted in a lack of consistent leadership for the MBA counties. Despite the findings of the RDANAP reported in 1980, it was only in the past year that California's rural/frontier counties

were able to clearly identify the membership of what is now the MBA Committee.

Furthermore, California's SSA has not identified a specific unit or staff person to support the MBA counties consistently. Frequently, State analysts assigned to the individual MBA counties are reassigned after short periods of time. This has resulted in MBA counties' having to continuously train new State analysts in their unique problems and needs.

The inability of MBA counties to consistently access assistance from California's university system has made it virtually impossible for any of the MBA counties to successfully compete for grant dollars from Federal agencies. Without the system's resources, the counties fail to develop the acceptable evaluation strategies required of all Federal grant programs. Thus, California's rural/frontier counties are left dependent upon minimum allocations of State and Federal dollars distributed by the SSA.

Whereas some of California's urban counties may have millions of additional treatment dollars as a result of direct Federal grants that supplement their allocations from the SSA, none of the MBA counties has successfully accessed direct Federal dollars. In fact, of the 22 direct Federal grants to "rural programs" in California, **none** are in the 19 MBA counties. As rural States are able to access support from their State universities, so are California's urban counties with rural areas. Consequently, a person living in a rural area of San Bernardino County is much more likely to be able to access a full range of drug and alcohol treatment services than are the nearly half-million persons living in the 19 MBA counties.

As described in the California Rural Needs Assessment Project and more recently in a study by the American Institute for Research (1992), the 19 MBA counties are most likely to have small staffs (averaging fewer than 6 counseling and prevention staff persons), with the program director usually providing both management and clinical services. These clinic directors are most often appointed because of their clinical skills rather than their extensive management backgrounds.

The isolation of MBA counties, their lack of resources, and the clinical responsibilities of their directors make it difficult for consistent leadership to come from the MBA counties themselves. This lack of consistent leadership, combined with the benign neglect of Federal and State decision makers and California's public institutions, leaves the MBA counties without the leadership necessary to adequately address their alcohol and drug program needs. Consequently, most of the twelve drug abuse treatment problems identified in rural counties in the 1980 RDNAP report continue to be problems 13 years later (see figure 2).

Funding Issues for MBA Counties

California's MBA counties continue to struggle to provide what most urban counties and even rural States consider to be basic service delivery systems. Most of the MBA counties were very slow in developing services for alcohol and drug abuse and currently lag behind in the development of specific services, such as perinatal programs for pregnant and parenting women. This is largely the result of a rural culture that is reluctant to accept Federal—or even State—mandates, and which looks to the individual to "solve his or her own problems." The boards of supervisors in several of the MBA counties have even prevented their program administrators from accepting the perinatal allocations available to them from the California Department of Alcohol and Drug Programs. In addition, the counties' inability to advocate or compete for funds has left them in the unenviable position of having to implement Federal and State priorities at the expense of basic services.

This situation will be exacerbated by the Federal reauthorization legislation, which requires nearly half of the Federal dollars to be spent on specific populations. Also, the HIV and tuberculosis testing requirements will place a disproportionate burden on MBA counties, which often do not have hospitals within their counties and must depend on the overburdened Public Health clinics, which are now losing funding as a result of California's budget crisis. It is the view of most MBA county administrators that implementing the Federal guidelines will decrease the services available as the cost of these services rises dramatically.

The problems inherent in categorical funding for MBA counties have been made difficult to respond to by a decision to "proportionalize" the amount of Federal and State money each county receives annually. As increased Federal funding came to California, administrators in some large counties became concerned that they were receiving smaller proportions of State general fund dollars and that this would leave their programs vulnerable if there were future cutbacks in Federal funding. The SSA decided to make the proportion of Federal and State dollars the same for all counties over a 3-year period.

Before proportionalization, the typical MBA county was receiving approximately 75 percent of its budget from the State general fund and the remainder from the Federal

Figure 2
Rural Drug Needs Assessment Project, 1980

Problems in Treating Drug Abuse

1. At the time of the project, many counties allocated less than one full-time position to drug abuse treatment. This results in a lack of personnel and skills to plan and provide comprehensive drug abuse treatment programs. Further, there is little opportunity to coordinate existing resources for these purposes.
2. Rural areas lack the training opportunities that could improve the effectiveness of their drug treatment staffs. Too many training programs are geared for urban populations and problems and are not suitable for rural personnel.
3. The shortage of personnel in all human service agencies, as well as their direct-service focus, inhibits county services from coordinating their efforts. Criminal justice personnel, for example, may not be aware of referral options for drug abuse treatment.
4. Advisors and information provided by the State have traditionally not been requested by or available to small counties. (This situation is changing, however.)
5. Local funds for drug abuse treatment and prevention are limited. Rural counties are unable to finance drug abuse treatment and prevention efforts, especially when the counties depend on a single industry such as logging or tourism, and when their seasonal unemployment rates are high. Rural counties also include large numbers of people who have incomes below the Federal poverty level.
6. Many rural counties are conservative; they hesitate to use Federal and State money for local programs, and they channel local money into public works programs rather than social service programs.
7. Complex contracting processes often discourage rural counties from applying for State or Federal funds available for drug abuse treatment and prevention activities.
8. Many rural counties assign a low priority to drug abuse treatment programs, which produces a correspondingly low level of service. The image of a drug user remains that of the Haight Ashbury hippie from the 1960s; populations that do not fit this description are simply not viewed as having drug problems. Thus, there is an inability as well as an unwillingness in rural areas to recognize the problem of drug abuse.
9. Rural drug abuse treatment programs are poorly coordinated as a result of distances, weather, shortage of personnel, and poor communication.
10. "Turfdom" politics at the local level and county-by-county regulations at the State level often discourage rural counties from coordinating regional efforts. (This is furthered by the county-matched funding requirement of the Short-Doyle Plan, which inhibits regional planning efforts. This requirement has been temporarily rescinded, however.)
11. The state of the art in drug abuse treatment is oriented toward urban needs. Treatment experts are not entering rural areas; rural drug abuse is less clearly defined, and rural treatment personnel frequently distrust urban resources.
12. Rural areas offer limited treatment options for drug abusers. The mental health-medical model is usually the only model available, and it may not be the most effective for many drug abusers.

block grant. Administrators in MBA counties were able to spend State general fund dollars on any service approved in the county plan as submitted annually to the SSA. This allowed MBA counties to support prevention and intervention programs, which were most often provided at local schools. This collaboration between MBA county alcohol and drug programs and county schools frequently provided the political support necessary to convince local decisionmakers to allow the development of alcohol and drug prevention and treatment services.

However, before the counties could develop a full range of services, the availability of State general fund dollars began to shrink and Federal dollars, which mandated spending in specific areas, replaced them. Because the total budget of an MBA county is relatively small, the discretionary dollars (both State and Federal) that were available had to be spent on categorical services to meet the mandates. For example, to meet the Federal Women's Set-Aside requirement, it was usually necessary to supplement the allocation of $5,607 by three or four times the allocated amount to be able to provide any service at all. The dollars deducted from the MBA counties State discretionary funds were transferred to urban counties, which were able to use them to meet the categorical funding requirements.

The ratio of State to Federal funds for MBA counties has now inverted, with approximately 25 percent of county budgets coming from the State general fund and 75 percent from the Federal block grant. This reduction in flexibility between funding streams has resulted in MBA counties spending virtually all of their allocation on mandated services, which often do not meet the priorities established by the local planning process. Because these priorities are not addressed, the administrators in the MBA counties sometimes find they do not have the support needed locally to implement the mandated programs (as is the case with perinatal programs).

The MBA counties lack access not only to major ancillary resources, such as hospitals, universities, and other public sector institutions, but also to ancillary treatment resources common in urban counties, such as private, nonprofit alcohol and drug program providers and private practice psychologists, social workers, and counselors. Well-funded service organizations, private employers, and foundations that provide funding to enhance urban programs are also unavailable in the MBA counties. This situation is best illustrated by the following example.

Friday Night Live, a high school-based alcohol- and drug-free recreation program that has been actively supported by the California Department of Alcohol and Drug Services, is funded in urban counties with donations from fast-food chains, local service organizations, and foundations. Because these resources are unavailable in most MBA counties, their Friday Night Live chapters are funded only with the $3,000 made available by the California Department of Alcohol and Drug Programs. As a result, some urban programs spend in excess of $300,000 to support Friday Night Live activities, while MBA counties must rely on the minimal allocation available from the State.

Summary

More people live in California's MBA counties than in some rural States. However, because of a lack of personnel and resources, scattered populations, great geographic distances, and a lack of infrastructure resources, the MBA counties continue to struggle to provide basic alcohol and drug services. They have been unable to compete with their colleagues in urban counties for additional funding, either through the SSA or directly from Federal sources.

MBA administrators supervise clinical staff, provide direct client services, and handle the voluminous mandatory paperwork. They often work without computers or use them only for straightforward tasks such as word processing, because no computer sales and programming services are available to them in their counties. If nothing else, these administrators are realists who accept the limitations of working in rural areas. They recognize the political obstacles they must face daily and do not delude themselves about the amount of influence they have with Federal, State, and university decision makers. Consequently, MBA county administrators have joined together to exert moral pressure (in lieu of political clout) as best they can. Furthermore, they recognize the necessity for structural changes at the Federal and State levels if the people needing alcohol and drug services in their counties are to be adequately served.

Recommendations for Improving Alcohol and Drug Services in Rural/Frontier Counties in Urban States

The California Rural Needs Assessment Project completed six regional plans in 1979 as part of its activities. Counties of varying

"rurality" were clustered into contiguous regions. All six plans identified the need for technical support, either from the Single State Agency or in the form of regional centers. Rural/frontier counties needed help in the areas of planning, grant writing, staff recruitment and training, program evaluation, and the development and maintenance of management information systems.

A group of MBA county administrators spent 2 days together in 1989 identifying their counties' problems and needs, including the need for ongoing regionalized technical assistance. A recent funding study of the counties by the American Institutes for Research also identified regional technical assistance pools as being necessary to remedy the lack of infrastructure in MBA counties. Thus, I would make the following recommendations.

First, the States, Federal agencies, or both should provide rural/frontier counties in urban States with technical assistance to enable them to plan programs, develop grants, and evaluate the programs' effectiveness. This should be done through regional centers controlled by the counties.

Second, Federal agencies must require urban States to define their rural/frontier areas and to assess currently available resources in and unmet service needs of these areas in the annual State plan. This recommendation was first made in a report of the Secretary of Health, Education, and Welfare (1979). The States' failure over the past 12 years to implement this recommendation in any meaningful way leads to my next recommendation.

Third, the Substance Abuse and Mental Health Services Administration should name a rural advocate at the national executive level who can lobby for the needs of rural States and rural/frontier counties in urban States. This recommendation can also be applied at the State level in large urban States such as California, where the SSA lacks an advocate for rural areas. Such an advocate might also sensitize and train State employees responsible for working with the rural/frontier counties.

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Building Community-Based Abuse Prevention Coalitions

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This paper is intended to provide an understanding of common terms and an assessment of the potential for community groups working in coalitions.

Introduction

Iowa State University Extension's (ISUE) Community Action For Abuse Prevention Program Committee has spent the past 2 years designing, developing, and delivering programs aimed at starting or strengthening community-based abuse prevention coalitions. The main focus of this effort is based on the premise that prevention education is the most effective long-term strategy to reduce abuse problems in rural communities. The committee further advocates the best use of limited human and financial resources in rural communities by suggesting that newly formed abuse coalitions develop prioritized strategies to address prevention of the most serious forms of abuse facing their local community.

According to *The Future by Design*, a publication of the U.S. Department of Health and Human Services (1991), "The current literature does provide important documentation of the diversity and complexity of prevention practice. Generally accepted categorizations of distinct approaches to prevention have been developed, including educational, effective skills building, peer support, positive alternatives, training of impacts, and environmental change approaches."

The ISUE effort is designed to support the publication's description of a community empowerment system where responsibility is shared, power resides with the community, and the community provides the expertise. In this system, actions are planned based on community needs and priorities, leadership comes from within the community, cooperation and collaboration are emphasized, decisionmaking is inclusive, and the community is maximally involved at all levels.

Methodology

The methodology used in the committee action plan includes the following assumptions:

- Awareness education at the community level is a primary concern for all collaborative abuse prevention efforts.
- Needs assessment and strategy development at the local level lead to greater ownership of problems and the potential to create an abuse-free environment.
- A better understanding of personal interaction and development, along with organizational development education, is needed to help collaborative efforts succeed.
- A sound premise in adult education involves modeling others' successes; adults learn best from dialogue with peer group members.
- Forming working partnerships is an effective tool for synergistic accomplishments. ISUE attempts to model partnering in its abuse program efforts.

The following section will describe the educational efforts developed and supported by ISUE in relation to these assumptions.

Awareness Education

ISUE has supported research-based awareness education in Iowa using the following print media:

- A series of pamphlets, *Understanding Abuse*, which provide detailed information about the various forms of abuse. There are seventeen pamphlets in the series, each detailing a different topic.
- A bimonthly newsletter for professionals, *About Abuse*,

which addresses current research and practice issues related to abuse. Each issue is devoted to a particular area of abuse and provides current information about Iowa activities related to abuse prevention.

- A resource directory which names, lists, and describes sources of educational support materials for conducting awareness programs at the community level.

These print resources are available in Iowa's 100 county extension offices, and are used by extension staff and coalition members in presentations to service clubs, church, and community groups, as well as in other presentations to raise awareness concerning the communities' abuse problems.

The ISUE Abuse Program Committee has partnered with a community group to produce a video for use in community awareness education. The video features a youth drama troupe presenting a series of vignettes depicting abuse from the youth perspective.

One segment portrays the relationship between an alcoholic mother and her son. The story relates how the deteriorating relationship leads to the boy's injury and separation from his mother. After rehabilitative treatment and counseling, the mother finds a job and asks to see her son. At first he rejects her wishes to make amends. Finally, after she assesses her new life by saying, "It's not much, is it?", he responds, "It's a start."

The video, along with a program leader's guide, is available in two formats. One contains only the drama; the other includes an interview with the director which deals with troupe replication for other communities.

Needs Assessment and Strategy Development

Stakeholder (total community) involvement in abuse prevention efforts is enhanced through the use of broad needs assessment and strategy development techniques. These help to create a shared community vision of an abuse-free environment.

Personal and Organizational Development Education

The ISUE Abuse Program Committee partnered with other Iowa organizations interested in abuse prevention to develop and deliver two satellite workshops. The 1992 program was aimed at starting or strengthening community-based abuse coalitions.

The 1993 program focuses on marketing the products or services of community abuse coalitions. Emphasis is on needs assessment, action planning, product development and delivery, and evaluation. Each program includes individual study packets with worksheets designed to assist program participants to form basic coalitions.

The satellite workshops also include a locally facilitated, process-modeling workshop designed to allow discussion comparing participant experiences to those portrayed in the satellite-delivered portion. Participants call in questions and comments to an expert panel for response. This methodology provides education-ally sound interaction through electronic delivery. Iowa's Lt. Governor Joy Corning has been a presenter in both workshops and has inspired Iowans in their work to control abuse.

Adult Education (Peer Group Dialogue)

The ISUE Abuse Program Committee partnered with three other agencies to sponsor a conference entitled, "Family Secrets . . . Pass Them On?" The program was attended by over 150 Iowa professionals and individuals interested in the interactive workshops offered as part of the program. John Freel keynoted the conference. His speech helped participants to understand addictive relationships and how they contribute to abuse concerns.

Forming Working Partnerships

The ISUE Abuse Program Committee models its assertion that project synergy comes from collaborative partnering efforts. These partnering efforts are designed to develop and deliver many of the programs and activities supported by the committee.

Program Content

Much of the content of the program effort is described generally under the methods section. A sample of the print media program materials will be included here. The sample demonstrates the kind of help the committee provides to support collaborative efforts at the community level.

How To Build Coalitions—Collaboration

Much discussion must occur before partnering at the community level can take place. However, discussion can falter when

participants don't speak the same language. The following definitions can help participants reach desirable goals.

- **Networking:** The process of sharing information between agencies. These agencies may or may not have common goals.
- **Collaboration:** The process of agencies sharing information and resources to achieve common goals.
- **Coalition of alliance:** A group of agencies or organizations collaborating under a formal structure for a common purpose to be more efficient and effective.
- **Partnership:** An association of agencies or organizations working together to eliminate needless competition.

Why Collaborate?

Agencies and organizations working together can bring about worthwhile community action. However, collaboration does have disadvantages. Before collaborating, both the positive and negative consequences of coalition action need to be evaluated as thoroughly as possible.

Advantages

The advantages of collaborating may be immediate or long term, direct or indirect. If there are no immediate or direct benefits to the group, there may be long-term or indirect benefits. It is essential that each partner believes that the benefits outweigh the costs of participation.

Frequently described advantages of belonging to a coalition are

- Effective and efficient program delivery
- Improved professional development
- Improved communication
- Elimination of duplication
- Increased use of programs
- Improved public image
- Better needs assessment
- Consistency of information
- Increased availability of resources

Becoming a partner in a coalition can offer many resources to the innovative group: new staff skills, new knowledge, new equipment and facilities, and new services. Combining the resources of two or more agencies can help deliver more services for the same money or the same services for less money through economies of scale, reduction of duplication, and improved cost-benefit ratios. When group members interact with partners from other groups, they will be exposed to new methods and ideas and become aware of new resources.

Improved communication between partnering agencies and organizations will result in

- More consistent and reliable information to clients
- An increased use of programs
- Better understanding of policy and legislative issues
- Better direction given to clients
- Improved evaluation of programs

Another advantage to collaboration is coordinated needs assessment. A group of service providers working together can better identify gaps in services. They also can identify more critical problems and set a course of action that makes better use of available resources.

Disadvantages

Some disadvantages of working through a coalition are the following:

Turf protection and mistrust must be overcome. If collaborative partners mistrust each other, they won't be receptive to new ideas, nor will they be willing to share resources. Most of the advantages of working together are lost; in fact, there may be negative outcomes.

Reaching consensus can take time. Many partners may need approval of a higher authority or more study time. Depending on how well the group communicates or how often it meets, decision by consensus can make acting on an issue slow and ineffective.

Limited resources may cause otherwise valuable partners to decide not to collaborate. Devoting resources to a coalition may reduce resources available for other high-priority projects.

Taking a policy position that is inconsistent with one of the partners may cause that partner to be uncooperative or ineffective, or to drop out.

Members in crisis may cause cooperation to decrease. Member organizations are sometimes faced with internal crises, such as budget cuts, changes in administration, or other short-term problems. The coalition may face its own crisis, such as the withdrawal of a key member or pressure from outside groups that disagree with or do not understand the coalition position. These tensions may strain the partnership.

Findings

Human, financial, and social resources in rural communities are continually being depleted. Community groups and organizations within and between communities must explore methods to make program delivery more effective and efficient.

Rural communities are becoming more diverse economically, socially, and culturally. The close-knit rural community that fights alone against abuse is a myth today. Abuse prevention promoters must work hard to help the community create a shared vision of an abuse-free environment.

Conclusions

Agencies and organizations which support community action for abuse prevention must find ways to spread scarce resources to help

build awareness and provide prevention education at the community level. Prevention education is an effective long-term strategy and must be supported along with intervention and treatment efforts.

Recommendations

Government support services need to become financial as well as physical supporters of prevention education. Local groups and organizations need more sources of information and support as they go about building family-friendly communities.

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Cultural Diversity as a Positive Force in the Treatment of Native American Alcohol and Other Drug Abuse

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This paper examines cultural research done by experts in Native American studies to identify a path for overcoming cultural barriers in the effective treatment of alcohol and other drug abuse (AODA). The first section of this paper briefly summarizes data relevant to the incidence and prevalence of AODA and their health consequences for Native Americans.

The second section looks at the cultural uniqueness of traditional Native Americans and focuses on value preferences and extended family relationships. The survivor syndrome theory explains perceived negative attitudes and tolerance of AODA in Native American communities.

The third section advocates acceptance of the cultural diversity of Native Americans as fellow Americans and advocates continued education for human services workers. Cultural barriers often lead to common errors when human services workers communicate with Native Americans. These errors include stereotyping, assuming affiliation, fearing silence, discounting denial, and trust busting. Summarized research findings and conclusions support the use of information about cultural diversity as a positive force in AODA treatment. Recommendations include training in cultural diversity, supporting community outreach programs that involve whole communities, suggesting a celebration of sobriety within State and national parks, and advocating the revision of existing AODA treatment programs to reflect a more flexible attitude regarding cultural diversity.

Introduction

This paper is based on the following four basic premises:

- Rural and frontier areas of America need cost-effective AODA treatment for Native Americans.
- High rates of AODA incidence and prevalence, along with their pathology and mortality, are destroying Native Americans.
- Cultural barriers block the success of conventional AODA treatment methods for Native Americans.
- Understanding and accepting cultural diversity can be a positive force in AODA treatment.

This paper explores cultural research in Native American studies to identify a path for overcoming cultural barriers and for providing desperately needed, effective treatment services that involve the community.

Methods

Demographics and orienting facts underscore the prevalence of AODA and its health consequences for Native Americans. Prominent research identifies cultural differences, uncovers barriers to effective treatment, and finds existing positive aspects on which to build a service base. Research findings are used to draw conclusions and to recommend strategies to break through cultural barriers, and thus to improve existing service delivery and to develop new AODA prevention policies for Native American communities.

Orienting Facts Relevant to Native American AODA

States designated as rural areas have a high proportion of Native American residents, although the overall State populations count 50 or fewer people per square mile. Thus, politically, fewer voters, along with uninvolved electors, equal less policymaking power in Alaska, Arkansas, Arizona, Colorado, Iowa, Kansas, Maine, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Wyoming.

Demographic information from researchers in Native American studies is briefly summarized below to identify the scope of the AODA issue in rural States.

The Native American population nearly tripled between 1960 and 1980 — from 551,669 in 1960 to 1.4 million in 1980. As of 1980, 46 percent of Native Americans resided on identified reservations or tribal trust lands (Liebowitz 1991). The Bureau of Indian Affairs (Marshall et al. 1990) recognizes 312 tribes and 500 tribal villages, varying by entity size from under 100 persons to over 150,000 culturally diverse Americans (Marshall et al. 1990).

Morgan, Hodge, and Weinmann compared recorded diagnoses of alcohol dependence at all U.S. short-stay hospitals with those within Indian Health Services (IHS) delivery systems (cited in Marshall et al. 1990). IHS rates were 3.28 times higher.

Marshall and others (1990) compare Native Americans with all races in alcohol-related deaths by age group. The Native American death rate in the 15-24 age group was 11.4 times higher. Native Americans aged 25-32 had death rates 11.2 times higher, the 35-44 age group had rates 7.7 times higher, and the 45-54 age group had rates 4.8 times higher than rates for all races (Marshall et al. 1990). "Between 1983-85, one third of all Native Americans who died were under age 45 compared to 10 percent for the total U.S. population. The excess death of younger people is attributed to higher rates for homicide, suicide, accidents, and death attributed to alcoholism" (Project Cork, p. 2).

A survey of health indices related to AODA identifies thirteen different conditions among Native Americans that account for 92 percent of years of productive life lost before age 55 (Rhoades et al. 1987). These conditions represent 46 percent of all IHS outpatient visits and 73 percent of

Table 1
AODA-Related Conditions Among Native Americans[1]

Conditions	Percent of Total Productive Life Lost	No. of Deaths/100,000
Unintentional injuries	32.9	116.5
Infant mortality	18.7	12.6
Violence	13.5	43.1
Cardiovascular diseases	7.0	192.3
Alcoholism	6.5	52.7
Cancer	4.3	92.9
Respiratory diseases	3.6	42.2
Digestive diseases	2.3	24.2
Infectious diseases	1.8	13.6
Diabetes mellitus	.9	25.5
Chronic renal failure	.7	11.7
Pregnancy and childbirth	.1	0.0
All other causes	7.8	60.4

[1]Rhoades et al. 1987

total inpatient days. For Native Americans ages 15-45, the rate of productive life-years lost is twice that of the U.S. population as a whole. Unintentional injury (accidents) and violence (suicide and homicide) (first and third) represent non-disease-related needless deaths.

The health indices related to AODA, in order of productive life lost and number of deaths per 100,000, are listed in table 1.

The Cultural Uniqueness of Traditional Native Americans

Many of the attitudes of Native Americans in need of AODA services depend on the progression of the disease, the adjustment to the dominant culture, the known and practiced degree of heritage consistency, and previous life experiences. The ideas presented here are common threads of understanding found in sociological research and reflect a personal interest in traditional Native American heritage. However, service providers need to emphasize the individual over the culture.

Cultural Value Preferences

Attneave (1981) compares the cultural value preferences of Native Americans with those of middle class Americans. Traditional values were observed and discussed in 50 tribal groups. U.S. white middle class data are derived from research performed at Brandeis University, Massachusetts. Three answer choices were given in order of value preference regarding a life concept. For example, if the number one answer choice of "harmony with" given for the concept of "man's relationship with nature" were to become impossible, the second choice "subject to" would be used.

Table 2, condensed from Attneave's work (1981), illustrates the striking differences between the ways an average white middle-class person would choose to live life and the traditional ways of Native Americans. The information could help the human services worker who cannot communicate with a Native American client.

Extended Family Relationships

The peer and family groups are the strongest forces in most Native

Table 2
Comparison of Life Concepts of Middle-Class Whites and Traditional Native Americans

Life Concept	Middle Class	Native American
Human to nature	1. Control over 2. Subject to 3. Harmony with	1. Harmony with 2. Subject to 3. Control over
Time orientation	1. Future 2. Present 3. Past	1. Present 2. Past 3. Future
Relationships	1. Individual 2. Collateral 3. Lineal	1. Collateral 2. Individual 3. Lineal
Self-actualization	1. Doing 2. Being 3. Becoming	1. Becoming 2. Being=doing
Nature of human	1. Mixed 2. Evil 3. Good	1. Good 2. Mixed 3. Evil

American lives. The value preference of collateral interpersonal relationships is often symbolized by the "circle of life" or "sacred hoop" in Native American culture. Decisionmaking is generally a group process and must consider all the people who will be affected by such decisions. People related by blood, by marriage, and by community are all considered family.

The prevalence of alcoholism among white Americans is estimated as follows: 1 in every 10 Americans is alcoholic; each person's alcoholism pathologically affects four family members' lives and up to 40 lives in the community (workplace, highway, economy, and so on). Johnson reported that the alcoholic cirrhosis death rate for Native American women in the 15-35 age group was 36 times that of Whites (cited in Hurlburt and Gade 1984). When these two estimates are correlated, entire family and community groups of Native Americans are devastated by AODA and its mortal consequences.

Even when a Native American successfully completes AODA treatment, the return home is hazardous to sobriety. The tradition of peer group sharing is a powerful cultural tie; accepting what is offered, even alcohol, is just as important a sign of friendship as the act of offering. Even when a Native American intends to maintain sobriety, being excluded by the group may erode those intentions. In addition, isolation and boredom are common among younger and unemployed members of the community. Drinking adventures may be the most exciting, yet dangerous, activity. As noted earlier, unintentional injury or accident is the leading cause of death among Native Americans. This cause is closely related to the "drinking party."

Because of the community's uncertainty on how to react to intoxication, considerable enabling contributes to AODA among Native Americans. Enabling is the conscious, or very often unconscious, aid of AODA by family and extended family members. Moreover, because an intoxicated person is not considered to be in control of any actions, he or she is not punished for crimes committed while intoxicated. This lack may explain why intoxication is used to forgive erratic or violent actions that occurred during intoxication.

Survivor Syndrome Theory

Phoenix Indian Health Center researchers Beane, Hammerschlag, and Lewis (1980) define the active pathology in the Native American culture as survivor syndrome. They postulate that attempts by Christian settlers to subdue the "savage" prompted 100 years of enforced dependency on Federal Native American policy; the constant erosion of sacred culture, dislocation from homelands, controlled poverty, and humiliation have resulted in survivor syndrome.

Repetitive psychodynamic themes exhibited by survivors of long-term persecution include "guilt and self-loathing, an inability to cope with anger, chronic depression, impoverished object relationships, and long-term personality changes to persecution, distress and apathy. . . . Survivors feel an incredible rage, but have an inability to express the rage at the intended object because of real or fantasized threats of retribution" (Beane et al. 1980, p. 15). Unexpressed anger is internalized and acted out against self or extended family members. The researchers cite clinical manifestations such as high AODA rates, suicides, homicides, family disintegration, and social/educational failures (Beane et al. 1980).

Cultural Barriers to Effective AODA Treatment

Whereas the major barrier to AODA treatment, diminished funding, will require strong political action to solve, other important cultural barriers can be destroyed by information. Is it perhaps because white Americans share their country with Native Americans that they cannot accept the cultural diversity? Throughout history, white Americans have expected Native Americans to accept Christianity, greed for gold, land acquisition, formalized education, governmental systems, and various diseases. This attitude is a counter-productive debate over who did what.

Fortunately, the cultural diversity classes required by today's higher educational institutions will help graduates to overcome these cultural biases. In addition, social workers and counselors are being offered continuing education opportunities. The barriers examined here are related to communication—a human services worker's most powerful tool. Common communication barriers include stereotyping, assuming affiliation, fearing silence, discounting denial, and trust busting.

Stereotyping

The Old West stereotype of the drunken Native American is the shamed brave, enslaved by the whiskey jug, begging by the trading-post gate. The modern version has the crazy-drunk Native American fighting in the bars until passing out.

Neither of these accounts depicts the true disease and consequences of AODA. Moreover, the more charitable view of Native Americans as poor unfortunates to be pitied and coddled is equally false. The image of the Native American who needs AODA services is not static but reflects changes in the Native American community as well as the global community. Above all, human services workers must treat each person as an individual who has a serious disease.

Assuming Affiliation

When human services workers counsel anyone outside their ethnic group, they should obey the following advice: "Be yourself." "Above all, the therapist should not assume some affinity based on novels, movies, a vacation trip, or an interest in silver jewelry. These are among the most offensive, commonly made errors when non-Indians first encounter an American Indian person or family. Another is the confidential revelation that there is an Indian "Princess" in the family tree–tribe unknown, identity unclear, but a bit of glamour in the family myths" (Attneave, p. 57).

St. Germaine (1989) warns against the disaster of using tribe-specific information on a member of the wrong tribe; with over 250 tribes and years of migration, the chances of being right are very slim. Instead, human services workers need to talk to the client about heritage consistency. Through such dialogue, individuals can place themselves along a heritage continuum between traditional ways and contemporary lifestyle; in the process, valuable knowledge will be gained about the client.

Fearing Silence

Human services professionals tend to talk more than usual to learn about new people and their situations. However, for most traditional Native Americans, it is customary to observe and test before revealing information; there will likely be long silences broken only by short exchanges.

Experts advise "staying" with the person by using quiet attentiveness and open body language. Whereas extended silence in the white culture may be interpreted as a defense mechanism, Native Americans often consider it a sign of respect. Forcing a client to open up and tell all is considered therapeutic by many AODA counselors; when working with a person raised to revere emotional restraint, counselors may need patience.

Discounting Denial

In 12-step recovery programs, admitting to being powerless is step one. A historical (and probably well-placed) mistrust of the white man makes "admitting we are powerless" seem like cowardice to many Native Americans. Added to this mistrust is the power of denial. Counselors working with the chemically dependent person are aware of the denial process that impairs the client's reality concept. This denial process is a cross-cultural phenomenon.

However, as AODA counselors are learning to accept the cultural diversity of the Native American client, the denial process may be used to hide or minimize the consequences of AODA, to blame others for troubles, to divert attention to another topic, or to use emotional blackmail to avoid reality. With any or all of these forms of denial, counselors must confront the clients about their denial of AODA as a powerful disease and must reflect a true picture of its consequences and progressive ruination of lives.

Trust Busting

In these days of short-stay AODA treatment, it is more difficult to build the strong trust relationship between client and counselor that is essential to effective work. The communication barriers between most Native American clients and their caseworkers make this task even more formidable.

Trust is, at best, fragile. To avoid breaking the painstakingly established trust, (1) be yourself, and (2) do not promise anything you cannot deliver.

Findings

Rates of AODA-related deaths for Native Americans aged 15-32 are greater than 11 times that for other Americans; one-third of Native Americans who die are under age 45, and accidental death is the leading cause.

Health problems related to AODA account for 46 percent of IHS outpatient visits and 73 percent of inpatient days.

According to the Bureau of Indian Affairs, Native Americans are a culturally diverse group of people belonging to 312 tribes. Traditional Native Americans differ from the U.S. white middle class in their value preferences regarding major life concepts. Their priorities emphasize harmony with nature, a present time orientation, a large circle of extended family relationships, and the process of becoming a better person idealized as a goal (rather than achieving material success).

Family and peer group violence—along with mistrust, depression, and apathy—directly relate to survivor syndrome and to the tolerance of AODA within Native American communities.

Cultural barriers are formed by mistakes in communication. False judgments result from stereotypical thinking. Counselors should be

themselves while encouraging the client to talk about heritage; in addition, counselors need to remember that among Native Americans, extended silences do not signify a defensive attitude.

Denial of the consequences of AODA is a cross-cultural phenomenon that must be confronted during treatment of the disease; at the same time, the fragile trust relationship must be protected.

Conclusions

AODA is culminating in the destruction of Native American populations. Native American death rates are far greater than that of other Americans, particularly for those under age 45 who are dying in AODA-related accidents.

Sparsely populated States, such as the designated rural and frontier States, face fewer allocated AODA treatment days and diminished program funding. These same States, all of which have high proportions of Native Americans, need to improve the cost-effectiveness of their programs.

Cultural diversity has been a barrier to effective AODA treatment largely because of misinterpretations. Focusing on the individual always takes precedence over cultural background; nevertheless, counselors must consider the person's heritage as a frame of reference to form a positive therapeutic environment.

Cultural value preferences regarding major life concepts differ greatly between traditional Native Americans and average white middle-class Americans. This diversity accounts for miscommunication and false judgments.

Because extended family circles encompass large numbers of people within Native American communities, the pathology affects more people. Workers providing AODA services need to address the power of the peer group.

A knowledge of survivor syndrome will help human services workers to understand clients and their negative attitudes of violence, mistrust, depression, and apathy. Because knowledge is power, newly required classes in cultural diversity will help to eliminate biases through information sharing and open communication.

Recognizing commonly made mistakes, such as stereotyping, assuming affiliation, fearing silence, discounting denial, and trust busting, will give the human services worker a much better chance of helping Native American clients succeed in AODA therapy.

Finally, human service workers can use the knowledge of cultural diversity as a positive force in communication. Such knowledge will help workers break through cultural barriers and reach plateaus of progress in the battle of AODA treatment.

Recommendations

The following recommendations are made based on extensive research on Native American AODA, along with much thoughtful consideration regarding attainable goals:

- All human services workers, beginning with those in direct client contact, should have mandatory training in how cultural diversity relates to communication in the helping relationship.
- Community outreach programs for young people, such as Drug Abuse Resistance Education (DARE), must be developed, and Native Americans must assume leadership roles.
- Prevention programs must begin with young children and continue throughout the extended family, maximizing peer power within Native American communities.
- State parks and national parks in rural and frontier States should be used as host sites for integrated campouts for all persons who maintain sobriety; a fitting theme for these cross-cultural celebrations is "Harmony with the Universe."
- Existing AODA treatment programs need to be revised to reflect a more flexible, positive attitude about cultural diversity.

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Transitional Recovery

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This paper presents a simplified, cost-effective form of treatment for chemically dependent persons. Transitional Recovery is based in the community and costs approximately $6,000 for 90 days of treatment. The program consists of a 12-week educational lecture series; an independent living skills program; and one-on-one, group, and family therapy.

The approach to therapy is holistic. Both chemical dependency and life dependency are broken, and individuation skills are taught. The treatment has been implemented, is currently functioning, and can function for as few as four adult or eight adolescent clients. That these numbers are small is of particular importance in areas of limited population.

The administration of this program is quite simple. A nonprofit organization is established, and a board of trustees from the community oversees the operation of the facility. Staffing includes a therapist/administrator, co-therapist (possibly a practicum student), house manager, secretary/bookkeeper, and two to three staff assistants. A community-based residential facility for 8 adults and 16 adolescents is recommended. A 50-percent census will pay expenses. Startup costs should be recovered within 4 years. The program is voluntary: "If you do not like it here, you should leave; you are welcome to return at your discretion."

The clinical portion of the program has one purpose: To promote recovery from chemical dependency. No psychological testing is performed, and psychological issues are not addressed except in the context of recovery. Clients are screened for eating disorders, and those with other disorders of greater priority are referred.

Clients with these disorders may be treated at the facility but only *their dependency* is treated. This approach eliminates many extra costs. In addition, detoxification is not done at the facility; it is considered a medical process to be completed in a hospital.

Introduction

This paper provides an overview of what transitional recovery is and how it can be applied in areas of less dense population. These areas do not have the volume to support the frills that a high-volume market may support. The focus is cost-effective singleness of purpose.

Treatment Approach

The title of the program, Transitional Recovery, reflects a community-centered focus for the treatment of chemical dependency. This approach involves the community in the treatment to eliminate stigmas and to educate the community in the disease's effects. Transitional Recovery keeps clients in the community while they learn to recover and to build a support system. Other programs often isolate clients, making them feel like outcasts. Transitional Recovery encompasses environmental, family, and individual growth. Transitional Recovery is a holistic approach to the disease, and not just the individual.

Purpose

There is only one purpose to Transitional Recovery: To promote recovery from chemical dependency. This purpose is the "how and why" of its cost-effectiveness. No psychological tests are given; there is no recreational mandate. Problems are referred to the proper sources.

A good example is the detoxification process. Detoxification is a medical process that needs to take place in a hospital setting. Removing the chemical is medical; preventing the relapse and finding sobriety are combined functions of the transitional recovery facility and the community.

The majority of clients had previously received multiple treatments for chemical dependency but found success in transitional recovery because of its

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This paper is dedicated to Dale Stehno, who gave me the confidence to write again.—*Larry R. Seybold, M.S.*

singleness of purpose. The admissions are voluntary, and the vital assessment for admission is "Do you want help, and why do you want help?" Clients who only want to regain their driver's license, for example, are turned away. This approach is a key motivation for the community, because only clients who *want* to recover from chemical dependency are accepted.

Methods and Content

The methods used in Transitional Recovery are to develop a nonprofit corporation that is based on educating the community and providing a family atmosphere to clients who wish to recover from chemical dependency. The original mission limited the population to women, but lack of clients forced a change to coeducational.

The project was instituted in an eight-bed, community-based residential facility. There is a clinical component, an administrative component, and a living skills component designed to allow input from the community. The clinical portion of the program provides a 12-week educational lecture series (table 1), a three-phase behavioral program (table 2), and group and one-on-one therapy; in addition, family therapy is offered. Family therapy is voluntary, but strongly encouraged.

The foundation of Transitional Recovery is a 12-step model. However, the point of view differs from that of other 12-step programs. The focus is not on working the steps but on applying the steps to daily living. Clients study one step per week. During an informal morning group, each client states how, on the previous day, he or she lived one of the steps already studied.

Table 1
12-Week Lecture Schedule

Week 1	Grief A. Loss of (spouse, friend, family member), self-will, alcohol and other drugs B. Steps of grief C. Nonprocessed grief and effects on present life
Week 2	**Learning about feelings** A. Anger versus hurt B. Vulnerability to others C. Owning feelings D. Not taking on others' feelings
Week 3	Communication A. Assertiveness training B. Problem-solving C. Types of communication D. Learning to talk in feelings
Week 4	Confronting and replacing old behaviors A. Growth versus perfection B. Occupational therapy C. Thrill seeking D. Time management
Week 5	Growing up; taking on responsibility A. Escapes (mental, legal, and psychological) B. Halt of the mental process by alcohol and drugs C. Reality, giving up self-will, not blaming, focus on self-improvement
Week 6	**Spirituality** A. Steps 3 through 5 of 12-step program (surrender) B. Spirituality versus religion C. Spiritual awakening
Week 7	Sexuality A. Acceptance of oneself as is B. Sexual dysfunction (fear) C. Sexual dishonesty D. Sexual victimization (incest and rape) E. Acquired immunodeficiency syndrome (AIDS)

Table 1 (continued)
12-Week Lecture Schedule

Week 8	Gender issues A. Physical self B. Gender-specific support groups C. Self-image D. Types of and shedding of abuse (sexual, physical, and verbal)
Week 9	Alcoholism and the family Adult Children Of Alcoholics A. Abandonment (fear, anger, sadness, hurt, resentment, distance, and loneliness) B. Rigid roles C Family secrets D. Resistance to outsiders E. Personal privacy F. Resistance to change
Week 10	**The child within** A. Learning to have fun B. Nurturing self C. Hungry, angry, lonely, tired D. Learning to forgive and like self (self esteem through humility)
Week 11	**12-step program** A. History B. Home group C. Sponsors D. Darkside
Week 12	Relapse A. Dry drunk B. Relapse cycle C. Interventions in relapse

When the program is completed, the client understands the workings of each step and its application. This approach also provides a stable pattern so that the client can follow one step per week into middle and late recovery. This process includes continuing individuation and, later, differentiation.

The lecture series covers a broad spectrum of topics, ranging from early to middle sobriety. The lecture series is an ongoing group into which a client fits depending on the stage at admission. The series allows community participation. Community participants lecture in their areas of expertise, and staff members assist the lecturers. Exercises complement this participation. For example, each client is given "custody" of a teddy bear for 40 hours and instructed to treat the bear the way the client wants to be treated. Any bear left unattended is confiscated by the staff; clients are allowed to use baby sitters for short periods and are encouraged to play with the bears.

A relapse prevention plan is completed, and group feedback for interventions is assigned. A significant other is then consulted privately. The client reviews the plan and asks that the interventions be implemented. With adolescents, a family contract is mediated and signed. In addition, the family is asked to present a family first step at the graduation group. The content of the two programs is similar.

As table 1 shows, Transitional Recovery includes an extensive lecture series. This series works as well with the public as it does with the recovering population. Many times, the two populations can be combined to the benefit of both. Outside speakers make the series more enjoyable and provide a greater sense of expertise. This approach works as a marketing tool in a small population while also serving the community as a whole.

Behavior Modification Component

The behavior modification component involves three stages. The first stage is primary care, the second stage is median care, and the third stage is community care. The phases integrate the client into the community after a period of stabilization. Each phase lasts 4

weeks and offers specific benefits to the client. The focus is on achievement, not consequences. The consequences are natural; if a client wants to go out on Saturday afternoon, he or she needs to find a sober person from the community to go along. The benefits to the clients include building a support network, asking to have needs met, and discovering that they can do the same things sober as they did when using chemicals.

This approach once again involves the community. Without integration, clients would merely sit around the facility. With adolescent clients, the community volunteers are screened more closely and the times of curfew are adjusted appropriately. In addition, the first phase for adolescents requires a Cooperative Education Student Association teacher or tutor to monitor homework.

As shown in table 2, consequences are not mentioned. This is because the natural consequences will have a stronger impact on the client than any artificial stimuli. All clients must complete the goals, and exceptions are made only with the community's permission.

Three groups meet daily. The first is an informal process-and-step group, the second group is a therapy group, and the third is an educational group. (The independent living skills group meets separately from the other three groups.) In addition to the group time, at least one one-on-one therapy session is held per week. These sessions lessen progressively toward discharge. The one-on-one therapy usually starts with a psychological history that includes establishment of attachments, progression of development, and repetitive patterns. Problem-solving and exercises are implemented after this information is compiled. Cognitive focusing of the mind, affirmation, inventories, and empty chair are exercises that have worked well.

Family Therapy

Family therapy is the single best predictor of outcome, especially with the adolescent population. Adolescent therapy and family therapy focus on the family structure. Alcohol and other drug abuse (AODA) issues must be addressed educationally. Homeostasis and the point of view of the community both must change. The adolescent program may be used to determine whether out-of-home placement is needed in the first 30 days and to provide family therapy to promote the transition process. Participation by the parents is more effective than out-of-home placement, but participation is not always possible.

Often, the parental structure has failed; thus, parental roles need to be reestablished, coalitions changed, and the outside world allowed to enter. In the past, group homes have been used at great expense, which often allows parents to continue an irresponsible lifestyle and thus perpetuate the cycle.

This therapy also addresses an issue that is often ignored by small populations: gangs. When the family structure is strong, the community provides training and jobs. Gangs do not form. The gang is a response to a failed community and its failure to fulfill the needs of its youth. Adults must provide the leadership.

Adult family therapy works on reestablishing trust with the family. In the adult group, therapy focuses on the consequences of the disease. The therapy examines the methods of communication, education about the disease and its effects on daily living continuing into sobriety, and support groups. The therapy also examines the developmental movement of the family from its point of fixation, its structures, and its explanation. More intensive therapy is needed in later sobriety.

Finally, the most important ingredient is the family atmosphere. Because the buddy system and the independent living skills program are included in Transitional Recovery, clients must depend on each other and help one another for the common good. This approach not only helps to individuate but also teaches skills that break the codependent need to be taken care of. Transitional recovery allows differentiation to take place over a period of years and thus breaks the chain of dependency.

Independent Living Skills

The independent living skills program may be the best insurance against relapse that a person—especially a single person—has. Many people suffering from chemical dependency do not have the skills to live a life other than survival. Many skills of daily living that nonusers take for granted are foreign to the chemically dependent person. Chemically dependent people are held prisoner because they cannot balance checking accounts, complete tax forms, find sources of help, vote, purchase clothing, budget, shop for food, complete a résumé, successfully interview for a job, or obtain a driver's license.

Dependency and fear of abandonment are the biggest motivations in the lives of dysfunctional people. If treatment removes the chemical but does not teach the skills, the chemically dependent person will survive by finding another dysfunctional person to take care of him or her. The cyclical feedback structure of abuse holds the client in bondage.

The community needs to help in all these areas. Community

Table 2
Phases of Recovery

I. Phase I

A. Read chapters 2 and 5 (pp. 58-63) of *Alcoholic's Anonymous* (*Big Book*) and step 12 in *12 Steps and 12 Traditions* (*12x12*); discuss with your buddy. Complete first step worksheet.
   1. You may not receive or make telephone calls for the first 3 days, but calls may be made when the first step worksheet is completed and approved.
   2. You may attend outside meetings with a buddy.

B. Read step 2 in *12x12* and discuss with your buddy. Ask for and complete the second step worksheet. You may have one visitor when the second step worksheet is completed and approved; an approved visitor may be received for 2 hours.

C. You will obtain a temporary sponsor. You may attend 12-step meetings with a buddy or temporary sponsor.

D. Read step 3 in *12x12* and chapter 4 of the *Big Book* and discuss with your buddy or sponsor. Complete the third step worksheet, express an understanding of spirituality, and volunteer for morning meditation or evening dedication.
   1. You may have two visitors for 4 hours when the third step worksheet is completed and approved.
   2. You may have a 2-hour pass on Sunday afternoon if your behavior is appropriate.
   3. You may attend 12-step meetings on your own (adolescents must attend a prearranged meeting where staff will monitor arrival and departure and return to the facility).

E. Read step 4 from *12x12* and chapter 5 (pp. 64-71) of the *Big Book* and complete the fourth step. You will start the relapse prevention inventory and be a buddy to a peer. You will discuss reading with peers or a sponsor.
   1. You may receive a 4-hour pass.
   2. You may lead activities such as the morning stretch and step study groups.
   3. You may attend recovery activities with a buddy or sponsor; your curfew is 12:00 midnight for dances and workshops.

II. Phase II

Read step 5 from *12x12* and arrange to complete the fifth step with an outside source such as clergy or a sponsor. Continue to read the *Big Book* and steps 6 through 8 from *12x12* and discuss with your peers or sponsor. You must continue to work and show progress on a sobriety plan.

A. You may start a job search or return to work (school for adolescents).

B. You may escort peers to outside activities if appropriate (does not apply to adolescents).

C. You may have eight 10-hour passes.

D. You may plan senior members' graduation.

E. You may be a community leader.

III. Phase III

A. Continue to read steps 9 through 12 in *12x12* and discuss. You will complete a sobriety plan. You will complete and present a relapse prevention inventory to your significant other and request that interventions be taken. You will continue reading the *Big Book*.
   1. You may earn overnight passes with parents or significant other.
   2. You may attend outside activities on your own (adolescents must have a signed consent form from their parents).

B. You will attend graduation, which will include the following:
   1. A cake
   2. Five visitors
   3. Good-bye group
   4. Affected member's first step

participation allows the client to rejoin the community and allows the community to fulfill its duty. Lasting friendships are made, the community has an investment in the facility, and intolerance fades.

Postprogram Activities

Two other elements are vital to Transitional Recovery. First, a followup form is completed at 6 months, 1 year, and 2 years. In cases of relapse, this contract can lead to quicker response, reducing the time required to restabilize the client.

Second, a bridge group is established to bring back graduates. (A 90-day separation period is required to discourage dependence on the facility.) The bridge group participants instill hope and confidence in transitional recovery. Both postprogram activities have played vital roles in the continuing recovery process.

Facility Administration

The administration of the facility is simple. A board of trustees is appointed from the community; one-third of the members are elected every 3 years. Board members approve the hiring and firing of clinical staff and oversee the functioning of the organization.

The head therapist usually functions as both administrator and therapist and, many times, as family therapist. One other therapist is usually needed. (Two therapists are needed for the adolescent program.) A secretary-bookkeeper oversees office management. A house manager teaches and monitors living skills and oversees the maintenance of the facility.

Two or three staff assistants monitor the clients (four or five assistants are needed for the adolescent program). The use of graduate-level interns offers a low-cost, but highly skilled, staffing option. One staff member is also the volunteer coordinator and is responsible for obtaining releases and for recruiting and screening volunteers.

The facility should be able to function on a 50-percent census for adults (or eight adolescents). At this rate, the startup costs are recovered in 4 years. In addition, the community donates funds, dances are held, and services are rendered to encourage community participation and to raise funds. In most cases, the primary source of funding is the county department of social services. Primary care (first 30 days) costs $80 per day. The remaining 60 days cost $65 per day. Billing is completed every 30 days.

The county provides the paperwork in most cases. Costs of operation are passed along to the county in an annual contract that guarantees a minimum entitlement.

In addition, AODA assessment can help the community and the facility raise funds. Local municipal courts, attorneys, the department of transportation, and the department of vocational rehabilitation may need an AODA assessment.

Process notes are recorded in a Document Assessment Plan format, titled, and numbered to coincide with a master problem list. All material conforms to Joint Commission on Accreditation of Hospitals standards. Cases are reviewed weekly. Policy, the backbone of the facility, is reviewed every 6 months by a quality circle.

Findings

The study covered 1.5 years. Three clients did not complete the program. (One client did not want to comply with the rules; a disruptive client was removed and refused referral to the appropriate psychological source; a third client gave no reason for leaving.) Two clients relapsed postdischarge; both had discontinued medication and were stabilized within 2 weeks. One client, who had also discontinued medication, committed suicide 1 month after graduation. The remaining clients are sober to this point.

Conclusions

This cost-effective program fits the needs of small communities and can be adapted to larger ones. This "no frills" approach of transitional recovery has a very positive success rate. With health-care funding limited, the choices are 14 days in a hospital setting or 90 days in transitional recovery for the same cost.

Clients who made the most progress were those most lacking in social skills. Many clients found a "family" that they were able to join, separate, and differentiate from, thus allowing them to continue through the developmental process.

Recommendation

A facility of this type should not be owned by an individual, because a struggle for prestige may sabotage the process. Discretion in hiring is of the utmost importance; a person who fills a temporary need may be a burden in the long run. Ask for help; the community is waiting to respond.

Project TEA: Iowa State Penitentiary Substance Abuse Program

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Addict or not, there is an urgent need to spread the message of how dangerous it is to use alcohol and other drugs (AOD). An unwitting alliance of distilleries, tobacco companies, pharmaceutical manufacturers, advertising agencies, television, movies, and others purport a mythical lifestyle where the hip, slick, cool, and beautiful people live better through chemistry. In reality, those trying to live out this fantasy have entered a lifestyle whose downward spiral can only lead to destruction. The "king for a day" progresses to unemployment, family breakup, domestic violence, date rape, and prison.

Incarceration provides a population whose use of AOD ranges from recreational to hard core addiction. Traditionally, treatment has been the primary programming option for the Iowa Department of Corrections. But, in over 20 years of combined corrections experience, the writers of this paper learned that a monolithic approach to AOD use cannot effectively address this wide range of use. A new and improved treatment program is not seen as the answer, as there are many quality programs available. Besides, treatment programming is not always indicated.

Few would disagree that inmates are difficult to counsel and love to play games. So, prior to treatment, the staff sorts out those who would disrupt the treatment process. Then, after treatment, the staff holds the inmates' feet to the fire to ensure that they follow through with their treatment goals.

This is the foundation and uniqueness of Project TEA (Treatment, Education, and Awareness). Using a multilevel approach, the staff uses awareness and education to burst the king's bubble, to get the addict to the point where he or she is ready to confront addiction head on. Project TEA also sabotages a ploy the criminal addict counts on: Get staff to give up by being as nasty as possible, then blame the staff for giving up.

The pretreatment levels of awareness and education can function as a springboard to recovery, an elephants' graveyard for those unwilling to change, or a place for inmates who lie and finagle their way through treatment. But treatment counselors will persist no matter how many times inmates lie or slam doors in their faces. They will help participants to develop an agenda and network with community resources. Then it will be up to the participants to weave their own safety nets from the skills learned in treatment. Staff will be watching for those who do not follow through; they will still be there when they slip and fall and come back. Then the process can begin again.

Introduction

In 1989, when the war on drugs was in high gear, the Governor of Iowa and the Director of the Department of Corrections set the goal of establishing licensed treatment programs at all correctional facilities. To meet this challenge, the authors of this paper were selected to develop a program for the Iowa State Penitentiary (ISP). This marked the beginning of a 23-month process that led to the licensing of the ISP Treatment Program.

Licensing was just the tip of the iceberg. In 20 years of combined corrections experience, the staff had learned that (1) inmates were sent unnecessarily to treatment; (2) even with prior treatment experiences, some inmates were not ready for treatment; and (3) some inmates just wanted their tickets punched for a quick trip out. To meet these varied needs, the staff created a three-tiered program comprised of treatment, education, and awareness.

The goal of treatment is to engage the participant in activities

that support recovery through an abstinent, comfortable, balanced, responsible, and fulfilling lifestyle. As a prelude to treatment, awareness and education provide programming opportunities for the nonaddict and prepare addicts for their treatment experience. The purpose of awareness is to establish a foundation of common knowledge. This enables participants to recognize and discuss the addiction process and its consequences. Education strives to reactivate the participants' thinking processes, helping them discover the link between alcohol and other drugs (AOD) use and its consequences.

The objectives of awareness and education are threefold: (1) to prepare an addict to enter a recovery program and gain maximum treatment benefit, (2) to provide the nonaddict with a hard look at the reality of addiction, and (3) to provide "recycling centers" for those whose denial is a barrier to a fulfilling treatment experience.

A Far-Reaching Problem

AOD's effects on individuals, families, communities, and society at large are devastating. Premature deaths associated with nicotine use exceed 1,000 daily. Alcohol-related fatalities on our Nation's highways are the number-one cause of death for young people between the ages of 15 and 24. Health care costs associated with nicotine and alcohol put an additional burden on a health care system fast approaching its breaking point.

In addition, AOD has a significant impact on the criminal justice system. According to the Bureau of Justice Statistics (BJS), 77.7 percent of jail inmates and 79.6 percent of State prisoners have used AOD at some point in their lives. A 1989 study by the BJS found that 27 percent of jail inmates were under the influence of a drug at the time they committed their crimes, and 13 percent of convicted jail inmates perpetrated their crimes in order to obtain money for drugs. BJS also found that 36 percent of the victims of violent crime believed their assailants were under the influence of AOD (*Drugs and Crime Facts, 1991*).

Today our Nation's correctional facilities are bursting at the seams. Iowa's Department of Corrections is no exception. It currently operates at approximately 1,350 inmates over capacity. Many in corrections agree that current overcrowding can be directly attributed to addicted offenders (Valle 1991).

The foregoing is not meant to imply a causal relationship between the use of AOD and criminal behavior. It has been estimated that some 70 percent of Americans use alcohol, and the vast majority do not run out and perpetrate crimes. In 1985, Dr. Bernard Gropper of the National Institute of Justice reported that use of AOD was not necessarily the primary or only cause of violent crime, although it did seem to be a characteristic of violent offenders (Zawistowski 1991).

Despite this characteristic connection, only 15 percent of incarcerated addicts receive any type of chemical dependency counseling (Valle 1991). This is in spite of evidence reported by Dr. Gropper that reduced drug use translates into reduced levels of criminal activity (Zawistowski 1991).

Matching Inmate Needs to Programming

The need for AOD counseling is clear. A 1989 computer survey of inmate records found that a startling 96 percent of the ISP's 719 inmates used AOD to some extent.

The ISP sent inmates to drug treatment programs at other institutions for many years. Inmates often related that they only sought treatment to satisfy a request by the Iowa Board of Parole. Many of these inmates had been convicted on drug-related charges and the parole board wanted their use of AODs addressed prior to early release. After completing a treatment program, inmates frequently returned to the ISP stating it was a waste of time, even though their records showed many problems with AOD.

We suspected that the intense level of programming required by licensure and the willingness of inmates to enter treatment resulted in premature referrals. We felt that, of the 96 percent identified as having AOD problems, perhaps 10 percent were ready to enter treatment. But what about the other 86 percent? Programming was needed, but not always treatment.

We found ourselves in a unique situation. The ISP is the State's only facility housing maximum, medium, and minimum security inmates spread out over four locations. Its inmates serve sentences ranging from 1 year to life.

Our task became clear: Develop a service delivery strategy providing new programming alternatives that address AOD problems on several levels, with each level focusing on particular needs and building on the previous level(s).

Program Development

The primary question became: At what levels should we provide these programming alternatives?

Historically, the ISP had what could best be described as a study group. The study group brought about two important realizations: (1) it is possible to foster an understanding of and discuss the complexities surrounding addiction, and (2) participants can be encouraged to reflect upon and share their feelings regarding the use of AOD.

Staff envisioned combining our study group experience with the treatment accomplishments of our colleagues at other prisons. This would maximize our goal of providing programming alternatives to our three target populations: (1) recreational users, (2) habitual users, and (3) addicts.

The task became to develop a program where all three groups could begin. The first level of programming would tell the recreational user, "We'll be here," and would advance the habitual user and the addict to the next level. The second level would be a critical one for both staff and inmate. This level would sort out the participants by evaluating (1) the user's level of reliance on AOD, (2) ability to identify the negative consequences caused by AOD in his or her life, and (3) level of motivation in seeking treatment.

Again, we would need to say, "We'll be here" to both those who had developed the momentum to advance in their treatment and those who had not. In the past, too many inmates were dropped from treatment because they were not considered teachable. Our goal is to persist with such tough cases and have them repeat the first two levels. Perhaps the second time around, or after subsequent rounds if needed, the individual will develop the insight, motivation, or fortitude to make it through treatment.

It is important for the addict, and the criminal addict in particular, to know that the therapeutic community will never give up. A naive and unconditional, "Do what you will" should be replaced with, "We're here when you are ready."

There is a real danger that if dropped with no options, the addict criminal will say, "See, they don't care" to justify use of AOD and criminal activity. Our approach is designed to have three benefits: (1) to continue some level of programming, no matter what, to make clear that "We'll be here," (2) to better utilize scarce resources by repeating awareness and education, and (3) to enhance the quality of treatment by having motivated participants.

Program Structure

The awareness and education levels of the program are not licensed by the Division of Substance Abuse. Hence, compared to the treatment program, these levels do not need to be as intense and are not subject to the same level of confidentiality as is required for treatment. This allows greater flexibility in program design.

The study group experience at the ISP demonstrated that audiovisual programs sparked discussion and often prompted sharing of personal experiences. Recognition reactions to the video content were also regularly observed. The entire relaxed atmosphere of the study group removed much of the anxiety associated with intense treatment programs. Participation at this level also minimized the stigma of being in a treatment program.

A weakness of the study group is its lack of structure. The nondirected approach seemed too haphazard, which reduced its effectiveness. To minimize this weakness, staff sought to develop a curriculum for each of the two levels. Fourteen topics were identified for awareness and 26 for education. Each topic would be covered in an individual session with the theme presented by an appropriate video.

The Iowa Substance Abuse Information Center (ISAIC) serves as the State's substance abuse information clearinghouse and has an extensive collection of quality materials. The staff has developed an excellent working relationship with ISAIC, which has expressed its commitment to helping the ISP find materials related to substance abuse in the corrections setting. The ISAIC collection also includes culturally sensitive videos which add yet another dimension to the programming.

Awareness

The entry level of the program is awareness. Addicts are often unaware they are addicted; all they know for sure is that "life stinks and they are hurting."

For nonaddicts, awareness is a form of prevention, in that it aids recreational users in evaluating their use/reliance on AOD in social situations and helps them to cope. The fact that AODs do not yet present them with major life problems does not make these users immune to addiction.

It is felt that awareness information benefits the addict as well. As Dr. Fritz Pearls put it, "Nothing changes until it becomes what it is." If you need to fix something, you better know what is broken.

Awareness is a cognitive process designed to build an information base. "Doing the legwork" may not be full of glitz and glamour, but it lays the foundation for a solid recovery. With 96 percent of the inmates at the penitentiary using AOD, it is felt that all need to recognize the potential for addiction. Five general areas are addressed during awareness: (1) the nature of addiction,

(2) biopsychosocial factors, (3) the role of denial, (4) the self-destructive lifestyle associated with addiction, and (5) the hope of recovery.

Education

The inmate population does not fit neatly into the categories of addict and nonaddict. For habitual users, the use of alcohol and other drugs is not yet mandatory for them to cope or to make social situations satisfying or meaningful—it just makes them a lot more fun. Such individuals now teeter on the brink of addiction. Education strives to make habitual users aware of their vulnerability and to reach these inmates on an effective level as a form of intervention.

To accomplish this, education forces participants to take a serious look at the consequences of their AOD use. Habitual users need to see that coming to prison is not simply a part of some game between them and the criminal justice system; that their AOD use sends out ripples on a pond and affects those around them; and that, to those affected, these ripples are more like tidal waves. Though not yet obsessed with AOD, these habitual users can thus reassess their use before it crosses the line into uncontrolled abuse and addiction. For the addict, education challenges their denial; they begin to feel a need for help.

Many will drop out of programming after completing awareness and/or education, feeling they have obtained maximum benefit. Some will be more cautious in their use of AOD, avoiding the trap of addiction. Others will simply present their gold stars to release authorities. Many will bury their heads deeper in the sand and cling to their denial, but hopefully not as easily as before. For these inmates, we'll be there should they want to try again.

But, for the select few, the sojourn through awareness and education leads to that moment of truth when they acknowledge their addictions and seek appropriate treatment. For these individuals, treatment represents the hope for a new beginning.

Treatment

The goal of treatment is to have the participant engage in activities that will bring about identified changes in behavior. A guiding question is, "What are you going to do differently when confronted with challenges that, in the past, have led to using AOD?"

The First Task

The treatment team's first task is to serve as an agent of change that encourages new behaviors. The team utilizes a variety of tools: treatment plans, group and individual therapy, structured activities, and a host of others.

Project TEA presents recovery as a two-edged sword against AOD use. One edge represents abstinence and the other represents changes in total behavior. The objectives of abstinence are (1) to understand that one can never use any mood-altering substance, and (2) to associate with a group whose goal is to support abstinence, such as Alcoholics Anonymous (AA).

Abstinence alone will not produce recovery. AA calls it "white knuckling it." These individuals still think and act like addicts; they just do not use AOD. They are simply biding their time until they use drugs again.

For recovery to be fulfilling, it will also require changes in total behavior. Here the objectives are to help participants (1) make a commitment to a change process that helps them realize their potential; (2) abandon addictive "stinkin' thinkin'" and replace it with rational thinking processes; (3) take effective control of their lives by defining responsible behavior and holding themselves accountable for all their behavior; and (4) recognize recovery as a process with specific tasks as well as sticking points that can contribute to relapses into AOD use.

The Second Task

The second task is to aid the inmate in making the transition from treatment to the free community. In the past, there has been a hidden agenda fueling the fires of addiction, including blaming others, denial, shame, fear, waiting for the right program, and other rationalizations.

The task is now to develop an agenda that will support a program of recovery. The objectives are to (1) provide training that allows the inmate to weave his or her own safety net and to network with community resources, (2) provide a network with community correction agencies in order to facilitate the inmate's accountability for recovery and changes in behavior, and (3) help the inmate understand that he or she alone is responsible for recovery and for the active role he or she must play in an aftercare program.

The Final Task

The final task to be discussed is the important role Project TEA plays in networking institutions and community corrections to hold inmates accountable. Past experience has taught project staff that inmates often manipulate conditions to keep their parole agent in the dark. They claim the ISP is a warehouse without programming where they were cast adrift with neither goals nor direction. They describe a kind of ground zero game where one has to start from square one.

Therefore, during the treatment phase, the participant develops an agenda establishing goals in major life areas. A copy is forwarded to release authorities, for whom it is a powerful tool in measuring the inmate's progress. Project staff are currently developing a less extensive program for use at the awareness and education levels.

Findings

Definitive findings at this time are premature. However, the program's prognosis is favorable thus far based on feedback from field personnel and select case reviews.

Recently, project staff presented the networking and agenda concepts to a group of release authorities. Parole agents' caseloads are notoriously high. As a result, time often does not allow for development of individualized goals and a specific agenda to carry them out. Therefore, parole agents are supportive of any effort that aids them in holding an inmate accountable. Private sector agencies working with released felons have also applauded the agenda concept. They see development of an agenda and the accompanying network as enhancing the ability of offenders to get out of prison.

Individual stories, while isolated and unique, often carry more meaning than any accolade. One tells of a cocaine addict whose use led to sales and later to prison. Following treatment, his agenda led to appropriate aftercare and job placement through JTPA. While at the ISP he had become interested in computers. This interest grew into a college degree and a programming job at the trucking company with which JTPA had first placed him. This individual never tested positive for drug use and has been recommended for discharge from parole following several months of minimum supervision.

Upon release, 1-, 3-, 6-, 12-, 18-, and 24-month studies follow the progress of each treatment participant. Release authorities are asked to evaluate participants in such areas as use of AOD, achieving primary and long-term goals, overall performance, and use of a sponsor. It is hoped this data base will identify critical elements of the agenda and network.

Conclusions

As a pilot project, it is too early to draw longitudinal conclusions on the effectiveness of the program. However, conclusions have been reached concerning the soundness of the project's conceptual framework and utility.

Conceptual Framework

Project TEA was founded on the personal experiences and observations of the project staff. From these experiences and observations, the staff has learned that an inmate needs to be teachable prior to entering treatment. If the inmate is not teachable, treatment programming may only have a short-term effect, as it lacks the power to change a behavior pattern steeped in addiction. At the same time, staff believe it is possible to aid the inmate to become teachable.

While developing this pilot project, we sought corroborating references to support these intuitive suppositions. Tammy Bell, M.S.W., CAC, Director of Relapse Prevention Services for the CENAPS Corporation, has identified six specific tasks the AOD user performs prior to entering treatment. Ms. Bell considers these tasks as the last stage of active AOD use and the first stage of recovery (Bell 1991).

From the beginning, project staff held a strong belief in the value of its study group experience. University Associates has developed a five-stage experiential learning cycle, which appears to be an effective tool in maximizing the ISP study group experience and helping inmates to become teachable (University Associates 1990).

Program Utility

A program's value is often measured by its utility. In this regard, Project TEA has impacted three primary areas.

First, regardless of the offender's length of sentence or the extent of his or her AOD problem, Project TEA offers some level of appropriate programming. The awareness and education levels of programming also provide valuable tools to correctional staff in evaluating the inmate's need and preparation for treatment.

Second, the Parole Board regularly requires inmates to participate in awareness and/or education prior to release consideration. The availability of the 7-week awareness and 13-week education programs allows the inmate to address AOD use while the consequences of confinement are evident.

Finally, Project TEA plays an important role in holding inmates accountable by networking institutions to community corrections and resources.

Recommendations

Awareness and education are proving to be valuable tools in preparing inmates for AOD treatment at the ISP. It is also a valuable learning experience for inmates whose use of AOD has not crossed the line of abuse/dependence. It would, therefore, seem prudent at this juncture to expand and actualize this concept. To accomplish this, the following recommendations are made.

First, staff believes the compilation of a workbook for awareness and education would significantly add to this learning experience. Such a workbook would clarify and expand upon concepts presented during the program and serve as a valuable tool in evaluating participation. In addition, the workbook would function as a continuing source of information throughout the program and on into recovery.

Second, two full-time coordinators should replace four part-time staff. This would ensure program consistency and allow for individual counseling at the awareness and education levels. At the same time, it would free the current full-time staff to focus their energies on treatment programming.

Lastly, networking between the ISP, community connections, and community treatment centers should be strengthened and expanded. Effective counseling demands that participants be held accountable for their behaviors and goals established during programming. To capitalize on their treatment programming and ISP experiences, open communication must exist between project staff and the free community.

Implementation of the above recommendations would allow staff to evaluate more accurately the effectiveness of Project TEA. A longitudinal study would follow participants at all levels and document both progression in the disease process and strides made in recovery.

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